

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

1- FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <i>Werner Aalto</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>8/23/83</i>			2b. HOUR <i>245<sup>P</sup></i>			
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR <i>June 19, 1896</i>		6. AGE (IN YEARS LAST BIRTHDAY) 87 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Finland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Cecil Co</i> MD.			
10. CITY OR TOWN OF DEATH <i>EIKton</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Union Hospital</i>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Carpenter</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Const.</i>	

13a. STATE Md			13b. COUNTY Cecil		13c. CITY OR TOWN North East		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <i>2764 Biggs Hwy. 21901</i>	
14. FATHER'S NAME FIRST MIDDLE LAST <i>Johannes Aaltoen</i>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Maria Eufrosyne Helberg</i>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. <i>072-26-0481</i>		17. INFORMANT ADDRESS <i>2764 Biggs Hwy. North East, Md. 21901</i>					

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Rupture Abdominal Aortic Aneurysm</i> <i>4413</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>4 hours</i>	
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PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: *a*

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			

22a. I certify that (I) (this hospital) attended the deceased from <i>Sept</i> , 19 <i>63</i> , to <i>Present</i> , 19 <i>83</i> , that (I) (we) lost <i>above</i> the deceased alive on <i>23 Aug 83</i> , and that in (my) <i>own</i> opinion death occurred on the date and hour and from the causes stated above. (If not, I did not aut view the body after death.)							
22b. SIGNATURE <i>Robert J Gray</i>				DEGREE <i>MD</i>		22c. DATE SIGNED <i>8/25/83</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Robert L Gray</i>				22e. ADDRESS <i>EIKton, Md 21921</i>			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Cremation</i>		23b. DATE <i>8-26-83</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Cratin &amp; Ferris</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>W. Chester Chester Penn.</i>	
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24. FUNERAL DIRECTOR NAME <i>Crouch Funeral Home</i>		25a. DATE REC'D. BY REGISTRAR <i>AUG 29 1983</i>		25b. REGISTRAR'S SIGNATURE <i>J. C. ...</i>	
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed and retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death. Page 4 may be retained by the funeral director, page 3 by the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 1B shows any injury, or other traumatic event, the medical examiner must be notified once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		MONTH DAY YEAR		MONTH DAY YEAR	
FIRST MIDDLE LAST		8 8 83		8:50A <sub>M</sub>	
Mary J. Ahern					
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR	
Female	White	June 9 1908	75	MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH		
Pa.	U. S. A.		Cecil MD.		
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY		
Elkton Md.	Union Hospital	Retired			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)	13b. COUNTY	13c. CITY OR TOWN	13d. STREET ADDRESS		
Delaware	New Castle	New Castle	500 South Dupont Parkway 99999		
14. FATHER'S NAME	15. MOTHER'S MAIDEN NAME	17. INFORMANT			
FIRST MIDDLE LAST	FIRST MIDDLE LAST	ADDRESS			
Philip Dougherty	MARY E. Preston	William Ahern 300 River Rd. Elkton, Maryland			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	16b. SOCIAL SECURITY NO.	17. INFORMANT			
No	222-01-1538				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY:					
5150 IMMEDIATE CAUSE (a) BROWN CELL PNEUMONIA					
DUE TO, OR AS A CONSEQUENCE OF					
(b) PULMONARY FIBROSIS					
DUE TO, OR AS A CONSEQUENCE OF					
(c)					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?	
				YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
		P.M. 19			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 8-2-83, 19 to 8-8, 19 83, that (I) (we) lost saw the deceased alive on 8-8, 19 83, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE		DEGREE		22c. DATE SIGNED	
Rolando A. Najera		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		8/9/83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS			
Rolando A. Najera		105 EAST MAIN ST ELKTON MD.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE	
Burial	August 12, 1983	Cathedral Cemetery		Wilmington New Castle Del	
24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Edward M. McNamee		AUG 12 1983		John J. Conner	
Gee Funeral Home		539 East Main St. Elkton, Md.			



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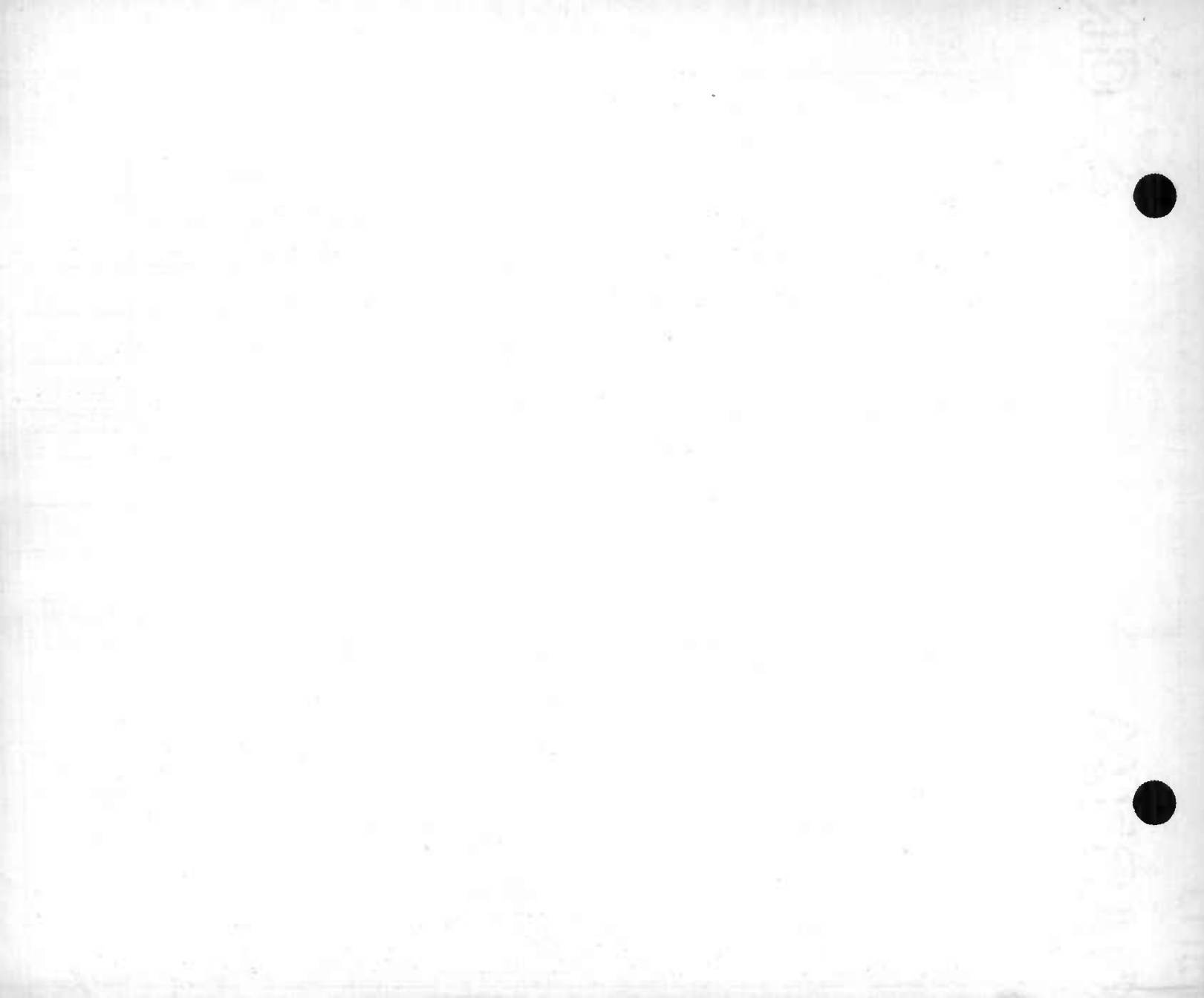
8-10-10

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death and be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.			
1. FOR STATE REGISTRAR				2a. DATE OF DEATH MONTH DAY YEAR			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Bessie L. Alexander</i>				8/22/83 5:30 P.M.			
3. SEX Female		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR 12 15 1920		6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS 62	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Cecil Co. MD.	
10. CITY OR TOWN OF DEATH Elkton		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Union Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Maryland		13b. COUNTY Cecil		13c. CITY OR TOWN Elkton		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Arthur		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ella Mae Richardson Wesley		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b. SOCIAL SECURITY NO. 219-20-5720	
17. INFORMANT ADDRESS Leon Alexander 116 Mallard Court Elkton, Md.		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a). <i>SEPTICEMIA</i> <i>2506</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (b). <i>DIABETIC GANGRENE ROTA LOWER EXT.</i> DUE TO, OR AS A CONSEQUENCE OF (c). <i>DIABETES MELLITUS</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <i>8-11</i> 19 <i>83</i> , to <i>8-20</i> 19 <i>83</i> , that (I) (we) lost saw the deceased alive on <i>8-20</i> 19 <i>83</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>Rolando Najera</i> DEGREE				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <i>8/23/83</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Rolando Najera, M.D.</i>				22e. ADDRESS <i>Elkton, Md 21921</i>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 8-27-83		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Cedar Hill, Maryland	
24. FUNERAL DIRECTOR NAME <i>Congo, Ernest M.</i> ADDRESS <i>201 N. Gray Ave. Wilm. Del.</i>				25a. DATE REC'D. BY REGISTRAR AUG 30 1983		25b. REGISTRAR'S SIGNATURE <i>John J. Connel</i>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It is to be retained by the hospital or attending physician.

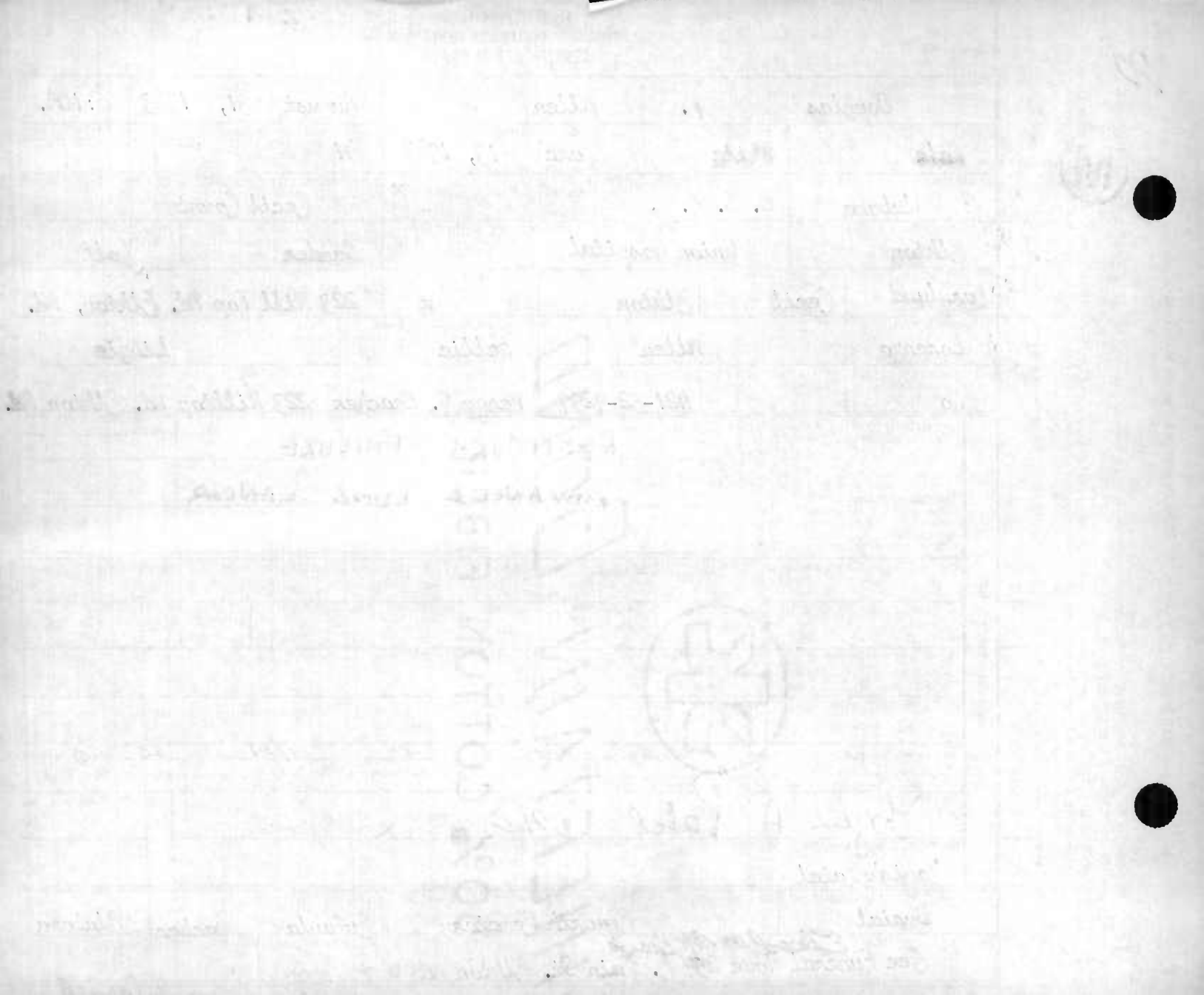
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified once.

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DHMH - 16 50M 1/81  
(VRA 15, 4)

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
1 - FOR STATE REGISTRAR					REG. NO.						
1. DECEASED NAME (TYPE OR PRINT) <i>Douglas M. Allen</i>					2a. DATE OF DEATH MONTH <i>August</i> DAY <i>31</i> YEAR <i>1983</i>					2b. HOUR <i>6:10A.</i>	
3. SEX <i>Male</i>		4. RACE <i>White</i>		5. DATE OF BIRTH <i>March 73, 1942</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>41</i>		IF UNDER 1 YEAR MONTHS <i></i> DAYS <i></i>		IF UNDER 74 HRS. HOURS <i></i> MIN. <i></i>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Alabama</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Cecil County</i> MD.					
10. CITY OR TOWN OF DEATH <i>Elkton</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Union Hospital</i>				12a. USUAL OCCUPATION (TYPE OF WORK OR MOST OF WORKING LIFE) <i>Sander</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Golf</i>			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <i>Maryland</i> 13b. COUNTY <i>Cecil</i> 13c. CITY OR TOWN <i>Elkton</i>					13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <i>223 Hill Top Rd. Elkton, Md.</i>				
14. FATHER'S NAME FIRST <i>Lorenzo</i> MIDDLE <i></i> LAST <i>Allen</i>					15. MOTHER'S MAIDEN NAME FIRST <i>Nellie</i> MIDDLE <i></i> LAST <i>Linzie</i>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i>					16b. SOCIAL SECURITY NO. <i>421-52-9299</i>		17. INFORMANT ADDRESS <i>Peggy J. Beacher 223 Hilltop Rd. Elkton Md.</i>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>RESPIRATORY FAILURE</i> <i>1629</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>ADVANCED LUNG CANCER</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i></i>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i>				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (1) (this hospital) attended the deceased from <i>8/24</i> , 19 <i>81</i> , to <i>8/31</i> , 19 <i>83</i> , that (we) lost saw the deceased alive on <i>8/30</i> , 19 <i>83</i> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>Yogish A. Patel</i> DEGREE <i>MD</i>								22c. DATE SIGNED			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Yogish Patel</i>								22e. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>				23b. DATE		23c. NAME OF CEMETERY OR CREMATORY <i>Fourth Cemetery</i>		23d. LOCATION CITY OR TOWN <i>Eufaula</i> COUNTY <i>Barber</i> STATE <i>Alabama</i>			
24. FUNERAL DIRECTOR <i>Edward M. McClary</i> <i>Yee Funeral Home 259 E. Main St. Elkton</i>						25a. DATE REC'D. BY REGISTRAR <i>SEP 7 1983</i>		25b. REGISTRAR'S SIGNATURE <i>John J. Connel</i>			



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 IN YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED IN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17  
(VR A15 ME (5))  
20M 4/82

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 21702	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Gary LEE Boggs						2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH DAY YEAR 8 22 1983		2b. HOUR a m			
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR 6-26-64	6. AGE (IN YEARS LAST BIRTHDAY) 19 YRS	IF UNDER 1 YR. MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	2c. DATE PRONOUNCED DEAD 8 22 1983		2d. HOUR 11:50 a m			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Elkton, MD		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Cecil County, MD					
10. CITY OR TOWN OF DEATH North East		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Maryland Materials Asphalt Plant				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Laborer		12b. KIND OF BUSINESS OR INDUSTRY Construction			
13a. STATE Maryland		13b. CITY OR TOWN Cecil		13c. CITY OR TOWN Elkton		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 17 Leeward Ct. Elkton, MD			
14. FATHER'S NAME FIRST MIDDLE LAST Ronald G. Boggs		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Janice Fern Day		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 217-96-9108		17. INFORMANT F. Day ADDRESS P.O. Box 210 North East, MD			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple injuries 9/199 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 8:30xx 8 22 1983		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Subject caught in moving parts of conveyor							
21d. INJURY OCCURRED WHILE AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) factory		21f. LOCATION CITY OR TOWN COUNTY STATE Md. Materials Asphalt Plant, North East, Cecil, MD							
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <i>Thomas D. Smith</i>				M.D. Deputy Chief, MEDICAL EXAMINER				DATE SIGNED 8/23/83			
EXAMINER'S NAME (TYPE OR PRINT) Thomas D. Smith, M.D.				ADDRESS 111 Penn St. Balto., MD.							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 8-25-83		23c. NAME OF CEMETERY OR CREMATORY Gilpin Manor Mem. Pk. Elkton, Cecil				23d. LOCATION CITY OR TOWN COUNTY STATE MD			
24. FUNERAL DIRECTOR NAME <i>John H. Crouch</i> Crouch Funeral Home				25a. DATE REC'D. BY REGISTRAR AUG 26 1983				25b. REGISTRAR'S SIGNATURE <i>John H. Crouch</i>			

MEDICAL CERTIFICATION

217-8-80

NOT RECORDED



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 3 2 1 7 0 3

FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>Jessie Mae CALDWELL</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>8/10/83</b>			2b. HOUR <b>3:02 PM</b>			
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>5 01 02</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>81</b> YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. <b>0 0 0 0</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Georgia</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Cecil</b> MD.			
10. CITY OR TOWN OF DEATH <b>Elkton</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Devine Haven Nursing Home</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE <b>MD</b>		13b. COUNTY <b>Cecil</b>		13c. CITY OR TOWN <b>Elkton</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>R.D. # 5 21921</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>George Caldwell</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Annie Brooks</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. <b>221-18-9127</b>		17. INFORMANT <b>Mr. Royce Caldwell, 372 Bethlehem Pike, Fort Washington, Pa.</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CONGESTIVE HEART FAILURE</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>ARTERIO-SCLEROTIC CARDIOMYOPATHY</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>4292</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>19034</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on <b>8-10</b> 19 <b>83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>Rolando A. Najera</b> DEGREE						ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>8-12-83</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Rolando A. Najera, M.D.</b>						22e. ADDRESS <b>105 E. Main St., Elkton, Md. 21921</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>8-13-83</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Gilpin Manor Memorial Park, Cecil, Md.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE		
24. FUNERAL DIRECTOR NAME <b>Ralph E. Hicks</b> ADDRESS <b>HICKS HOME FOR FUNERALS, ELKTON, Md. 21921</b>						25a. DATE REC'D. BY REGISTRAR <b>AUG 19 1983</b>		25b. REGISTRAR'S SIGNATURE <b>John J. Cairns</b>	

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

U.S. DEPARTMENT OF JUSTICE  
WASHINGTON, D.C. 20535

RECEIVED  
JUL 11 1964

7-11-64

TO: DIRECTOR, FBI  
FROM: SAC, NEW YORK  
SUBJECT: [illegible]  
RE: [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 21704			
1. FOR STATE REGISTRAR				2. DATE OF DEATH			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>CHARLES WILLIAM COLE</b>				MONTH DAY YEAR <b>August 17 83</b>		7b. HOUR <b>10:45a</b>	
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH (MONTH DAY YEAR) <b>Feb. 18, 1919</b>		6. AGE (IN YEARS (LAST BIRTHDAY)) <b>64</b> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Penna.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Cecil County</b> MD.	
10. CITY OR TOWN OF DEATH <b>Perry Point</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>VA Medical Center</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Upholsterer</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>US-govt. Ret.</b>	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Maryland</b>				13b. COUNTY <b>Harford</b>		13c. CITY OR TOWN <b>Havre de Grace</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>James -- Cole</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Edna -- Perkins</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>		16b. SOCIAL SECURITY NO. <b>365-18-2987</b>		17. INFORMANT ADDRESS <b>Mrs. Margie L. Cole, 2015 Chapel Road, Havre de Grace, Md. 21078</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <b>4860 IMMEDIATE CAUSE (a) Cardio Respiratory Arrest due to</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Respiratory Failure</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Bilateral Pneumonia</b>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>Nov. 12, 1969</b> to <b>August 17, 1983</b> , that (I) (we) last above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>Julian Ocejio</b>				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>8/17/83</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>JULIAN OCEJO</b>				22e. ADDRESS <b>VAMC, Perry Point, MD 21902</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>Aug. 22, 1983</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Harford Mem. Gardens</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Aldino Harford Md.</b>	
24. FUNERAL DIRECTOR <b>Howard K. McComas III, Abingdon, Md. 21009</b> <b>McCOMAS, Howard K III Funeral Home, Cokesbury Rd, Abingdon, Md.</b>				25a. DATE REC'D BY REGISTRAR <b>AUG 19 1983</b>		25b. REGISTRAR'S SIGNATURE <b>John J. Conish</b>	

BP

(M)

CHARLES WILLIAM COLE August 17 03 10:45

VA Medical Center  
Perry Point  
New York  
See 18-2027  
1903

Cardio Respiratory Arrest due to  
Respiratory Failure  
Bilateral Pneumonia



XXXXXXXXXXXXXXXXXXXXX  
Nov. 12 03 August 17 03

WMC, Perry Point, Md 21904  
JULIAN OCELO  
EX-103

Handwritten notes and stamps at the bottom of the page, including a large circular stamp.

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP/30

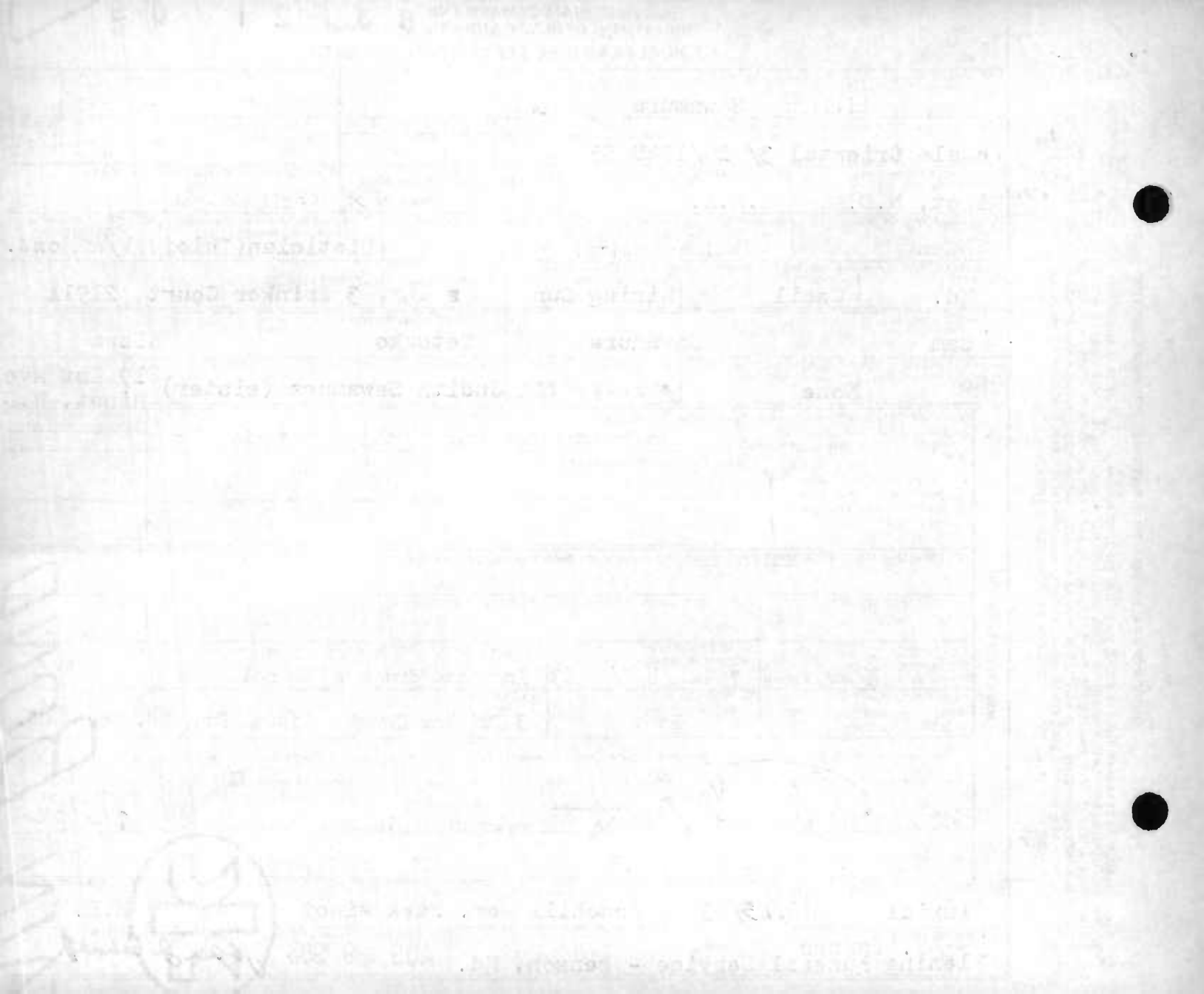
DHMH - 17  
(VR A15 ME (5))  
20M 4/82

FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE KNOWN OF DEATH			MONTH DAY YEAR			2b. HOUR					
Lillian Sawamura Daly						8 7 19 83						M					
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 1 YR.		IF UNDER 24 HRS.		7c. DATE PRONOUNCED DEAD		2d. HOUR			
Female		Oriental		3/ 29/1928		55 YRS.		MONTHS DAYS		HOURS MIN.		8 8 19 83		12:10 PM			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)				7b. CITIZEN OF WHAT COUNTRY?				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH					
Minot, N.D.				U.S.A.								Cecil County MD.					
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY					
Elkton				Union Hospital				Dietician (Chief)				V/A Hosp.					
13a. STATE				13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS							
Md.				Cecil		Rising Sun		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		3 Brinker Court 21911							
14. FATHER'S NAME						15. MOTHER'S MAIDEN NAME											
FIRST MIDDLE LAST Sam Sawamura						FIRST MIDDLE LAST Tetsuko Aizwa											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES?						16b. SOCIAL SECURITY NO.						17. INFORMANT ADDRESS					
No (YES, NO, OR UNKNOWN)						None (IF YES, GIVE WAR OR DATES)						50-24-2262 Judith Sawamura (sister) 819 1st Ave Minot, N.D.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)																	
PART I DEATH WAS CAUSED BY:																	
IMMEDIATE CAUSE (a) Acute combined drug & Ethanol intoxication																	
9805																	
DUE TO, OR AS A CONSEQUENCE OF																	
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost																	
(b) DUE TO, OR AS A CONSEQUENCE OF																	
(c)																	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																	
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY?					
												YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)									
				HOUR A.M. MONTH DAY YEAR ? P.M. 8/7/ 19 83				Ingested drugs & Ethanol									
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION									
				Home				3 Brinker Court Rising Sun, Md. Cecil Co.									
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/> .																	
ACTUAL SIGNATURE				TITLE (SPECIFY)				DATE SIGNED									
Thomas D. Smith, M.D.				M.D. Deputy Chief				8/9/83									
EXAMINER'S NAME (TYPE OR PRINT)				ADDRESS													
Thomas D. Smith, M.D.				111 Penn St, Balto, MD													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE		23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION							
Burial				8/15/83		Rosehill Mem. Park				Minot Ward COUNTY N.D. STATE							
24. FUNERAL DIRECTOR NAME				ADDRESS				25a. DATE REC'D. BY REGISTRAR				25b. REGISTRAR'S SIGNATURE					
E. Barnes				Fleming Funeral Service - Benson, Md.				AUG 19 1983				Joan L. Smith					



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. FOR STATE REGISTRAR		2. DECEASED NAME (TYPE OR PRINT) LUCY M. DANGERFIELD		3. DATE OF DEATH MONTH DAY YEAR AUGUST 19, 1983		4. HOUR p. M.	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR MAY 19, 1897		6. AGE (IN YEARS LAST BIRTHDAY) 86 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Kentucky		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Cecil MD.	
10. CITY OR TOWN OF DEATH North East		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 120 Red Toad Road 21901		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Maryland		13b. COUNTY Cecil		13c. CITY OR TOWN Elkton		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Alexander S. J. Marshall		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Jane Pennington		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 236-05-5350D	
17. INFORMANT ADDRESS Mrs. Freda M. Tyree, Elkton, Md. 21921		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ALZHEIMERS disease.</u> 3310 DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 YEARS.		PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME STREET FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>7/31/80</u> , 19 <u>80</u> , to <u>present</u> , 19 <u>83</u> , that (I) <del>was</del> lost saw the deceased alive on <u>19 AUGUST</u> , 19 <u>83</u> , and that in (my) <del>own</del> opinion death occurred on the date and hour and from the causes stated above. (I) <del>did</del> (did not) <del>view</del> the body after death.		22b. SIGNATURE <u>Robert L. Gray</u> DEGREE MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>8/23/83</u>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Robert L. Gray, M.D.		22e. ADDRESS 719 Bridge Street, Elkton, Md. 21921		23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 8-23-83	
23c. NAME OF CEMETERY OR CREMATORY Gilpin Manor Memorial Park, Elkton, Md. 21921		23d. LOCATION CITY OR TOWN COUNTY STATE		24. FUNERAL DIRECTOR <u>Hicks Home for Funerals</u> HICKS HOME FOR FUNERALS, ELKTON, MD. 21921		25a. DATE REC'D. BY REGISTRAR AUG 25 1983	
25b. REGISTRAR'S SIGNATURE <u>John J. Carver</u>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					REG. NO.	
1. FOR STATE REGISTRAR					83 21707	
1. DECEASED NAME (TYPE OR PRINT) <b>DAVID SCOTT DAVIS</b>					2a. DATE OF DEATH MONTH DAY YEAR <b>AUG. 25 1983</b>	
3. SEX <b>M</b>					2b. HOUR <b>3 A.M.</b>	
4. RACE <b>CAUCASIAN</b>					6. AGE (IN YEARS LAST BIRTHDAY) <b>4</b>	
5. DATE OF BIRTH MONTH DAY YEAR <b>12 9 78</b>					7. IF UNDER 1 YEAR MONTHS DAYS <b>4</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Md.</b>					8. IF UNDER 24 HRS HOURS MIN. <b>4</b>	
7b. CITIZEN OF WHAT COUNTRY? <b>US</b>					9. BALTIMORE CITY OR COUNTY OF DEATH <b>CECIL</b>	
10. CITY OR TOWN OF DEATH <b>Coloma, Md.</b>					11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>2447 Liberty Grove Rd, Coloma, Md.</b>	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>CHILD - NA</b>					12b. KIND OF BUSINESS OR INDUSTRY <b>N.A.</b>	
13a. STATE <b>Md.</b>					13b. COUNTY <b>Cecil</b>	
13c. CITY OR TOWN <b>Coloma</b>					13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>EMORY Lee DAVIS</b>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>BETTY JEAN HANKS</b>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>					16b. SOCIAL SECURITY NO <b>N.A.</b>	
17. INFORMANT ADDRESS <b>PARENTS - 2447 Liberty Grove Rd, Coloma, Md.</b>						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <b>Generalized Bleeding</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Thrombocytopenia</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>JUVENILE CHRONIC MYELOID LEUKEMIA</b>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>24 hours</b> <b>5 mos.</b> <b>5 mos.</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)						
19a. DATE OF OPERATION <b>N.A.</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>N.A.</b>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) <del>(the hospital)</del> attended the deceased from <b>3/29</b> , 19 <b>83</b> , to <b>8/25</b> , 19 <b>83</b> , that (I) <del>(we)</del> lost saw the deceased alive on <b>8/18</b> , 19 <b>83</b> , and that in (my) <del>(our)</del> opinion death occurred on the date and hour and from the causes stated above, (I) <del>(we)</del> (did) (did not) view the body after death.						
22b. SIGNATURE <b>Allen D. Schwartz, M.D.</b>					22c. DATE SIGNED <b>8/25/83</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Allen D. Schwartz, M.D.</b>					22e. ADDRESS <b>U. of Maryland Hospital Balto, Md. 21210</b>	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>Aug. 27, 1983</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Bel Air Mem. Gardens</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Bel Air Harford Md.</b>
24. FUNERAL DIRECTOR NAME ADDRESS <b>Howard K. McComas III, Abingdon, Md. 21009</b>					25. DATE REC'D. BY REGISTRAR <b>AUG 29 1983</b>	
					25. REGISTRAR'S SIGNATURE <b>John J. Connel</b>	

Aug 22 1983 A

DAVID SCOTT DAVID

M CAUCASIAN 12 P 58 H

MR. 20 CECIL

Colorado, Mr. 2440 Liberty Avenue Rd. - N.A.

Mr. Cecil Colorado -

BETTY JEAN HANKE

Parents - N.A. 2440 Liberty Avenue Rd.

Generalized Bleeding

Thrombocytopenia

2040 Liberty Avenue Rd. N.A.

N.A. N.A.

8/22 8/22 8/22

Allen D. Schwartz, M.D. West Maryland Hospital  
8/22/83

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

FOR  
1. STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>EDWARD W. DAVIS, Jr.</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>August 1, 1983</b>		2b. HOUR <b>1:47pm</b>					
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>April 10, 1921</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>62</b> YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Cecil County, MD.</b>				
10. CITY OR TOWN OF DEATH <b>Perry Point, Md.</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (GIVE STREET ADDRESS) <b>VA Medical Center</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Engineer</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Civil</b>		
13a. STATE <b>Maryland</b>			13b. COUNTY <b>Harford</b>		13c. CITY OR TOWN <b>21047</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>716 Old Fallston Road</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Edward Walter Davis, Sr.</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Florence Little</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>			16b. SOCIAL SECURITY NO. <b>W.W.11 220-03-6104</b>		17. INFORMANT ADDRESS <b>Mary K. Davis Fallston, Maryland 21047</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: <b>1629 IMMEDIATE CAUSE (a) Bronchopneumonia, bilateral</b> DUE TO, OR AS A CONSEQUENCE OF <b>(b) Carcinoma of left lung w/metastasis to brain</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF <b>(c)</b>										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>0</b>										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>July 29</b> , 19 <b>83</b> , to <b>August 1</b> , 19 <b>83</b> <b>XXXXXXXXXX</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (and) (did not) view the body after death.										
22b. SIGNATURE <b>[Signature]</b>			DEGREE			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>8-2-83</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>M. N. ATAY, M.D.</b>			22e. ADDRESS <b>VA Medical Center, Perry Point, Md.</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>			23b. DATE <b>Aug. 3, '83</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Green Mount Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore, Maryland</b>			
24. FUNERAL DIRECTOR NAME ADDRESS <b>Johnson Funeral Home, Baltimore, Md.</b>					25a. DATE REC'D. BY REGISTRAR <b>AUG 4 1983</b>					

BP \_\_\_\_\_

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the Medical Examiner must be notified at once.

10/1/83

August 1, 1983

DAVIS, Jr.

M.

CONRAD

10/1/83

August 1, 1983

DAVIS, Jr.

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August 1, 1983

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10/1/83

August 1, 1983

DAVIS, Jr.

M.

CONRAD

21709

1 - FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH		MONTH		YEAR		2b. HOUR							
EDWARD		James		DOBRY		Sr.		August 15, 1983						11:15am							
3. SEX		4. RACE		5. DATE OF BIRTH				6. AGE (IN YEARS LAST BIRTHDAY)				IF UNDER 1 YEAR		IF UNDER 24 HRS.							
Male		White		Sept. 5, 1989				93				YRS.		MONTHS		DAYS		HOURS		MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH													
Maryland		U.S.A.						Cecil County MD.													
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN BALTIMORE CITY, GIVE STREET ADDRESS)										12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY					
Perry Point, Md.		VA Medical Center																			
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS													
Maryland		St. Mary's		Great Mills		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		General Delivery 20634													
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		ADDRESS																	
Thomas		Mary		?																	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT																	
Yes		WWII		213-20-3852		James Dobry															
				Chancellors Run Road																	
				Great Mills, Md. 20634																	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																			
4292		IMMEDIATE CAUSE (a) Cardiac arrhythmia																			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last		DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic cardiovascular disease																			
		DUE TO, OR AS A CONSEQUENCE OF (c)																			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c)																					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?											
								YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>											
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)															
		HOUR A.M. MONTH DAY YEAR																			
		P.M. 19																			
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				21f. LOCATION															
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK						CITY OR TOWN COUNTY STATE															
22a. I certify that (this hospital) attended the deceased from June 28, 1968, to August 15, 1983, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.		22b. SIGNATURE																22c. DATE SIGNED			
		Louise Sultan																8-15-83			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS																			
LOUISE SULTAN, M.D.		VAMC, Perry Point, Md.																			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY						23d. LOCATION											
Burial		8/18/83		Holy Face Cemetery						CITY OR TOWN COUNTY STATE											
										Great Mills St. Mary's Md.											
24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR																25b. REGISTRAR'S SIGNATURE			
NAME ADDRESS		AUG 22 1983																			
Mattingly Funeral Home, Leonardtown, Md.																					

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 3 through 6 shall be placed in the container with the body. Pages 1 and 2 should be filed with the health officer.

**IMPORTANT:** If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

11:38am

August 12, 1963

ROBERT

THOMAS

Barry Point, W.D. VI Medical Center

Cardiac arrhythmia

XXXXXXXXXX

83

August 1963

83

June 20

XXXXXXXXXXXXXXXXXXXXXXXXXXXX

8-18-63

xx

W.D. Barry Point, W.D.

LOUISE SULTAN, W.D.

80% COL

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be called and a copy of the report filed with this certificate.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.			
1. FOR STATE REGISTRAR							
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>ROBERT A. EVANS</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>August 31, 1983</b>		2b. HOUR <b>8:00am</b>	
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>April 14, 1909</b>		6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS HOURS MIN. <b>74</b> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Cecil County</b> MD.	
10. CITY OR TOWN OF DEATH <b>Perry Point, Md.</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>VA Medical Center</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Police Officer</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Pocomoke City</b>	
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Worcester</b>		13c. CITY OR TOWN <b>Pocomoke</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Major Evans</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Margaret Tyler</b>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> (IF YES, GIVE WAR OR DATES) <b>W. W. II</b>			
16b. SOCIAL SECURITY NO. <b>220-01-8051</b>		17. INFORMANT <b>Beulah M. Evans</b>		ADDRESS <b>Same as 13 a,b,c,d,e</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac Arrest, sudden</b> 4149 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Old Myocardial Infarction</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Arteriosclerotic Coronary Artery Disease, severe</b>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>Cholelithiasis</b>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (X) (this hospital) attended the deceased from <b>August 23</b> , 19 <b>83</b> , to <b>August 31</b> , 19 <b>83</b> XXXXXXXX and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (do) (did) not view the body after death.							
22b. SIGNATURE <i>[Signature]</i>				DEGREE <b>ATTENDING PHYSICIAN</b> <input type="checkbox"/> <b>MEDICAL DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYSICIAN</b> <input checked="" type="checkbox"/>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>M. N. ATAY, M.D.</b>				22e. ADDRESS <b>VA Medical Center, Perry Point, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>9/4/83</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Sunnyridge Memorial Park</b>		23d. LOCATION CITY COUNTY STATE <b>Crisfield Somerset Md.</b>	
24. FUNERAL DIRECTOR NAME ADDRESS <b>BRADSHAW FUNERAL HOME, Crisfield, MD 21817</b>				25a. DATE REC'D. BY REGISTRAR <b>SEP 8 1983</b>		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>	

BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of same.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.			
1. FOR STATE REGISTRAR				2a. DATE OF DEATH MONTH DAY YEAR			
1. DECEASED NAME FIRST MIDDLE LAST (TYPE OR PRINT) Albert Paul Foard				Aug. 24 1983 M			
3 SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR July 31 1927		6. AGE (IN YEARS LAST BIRTHDAY) 56 IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Cecil Co. MD.	
10. CITY OR TOWN OF DEATH Colora		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1809 Liberty Grove Rd.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Concret Work		12b. KIND OF BUSINESS OR INDUSTRY Self Employed	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
13a. STATE Md.		13b. COUNTY Cecil		13c. CITY OR TOWN Colora		13e. STREET ADDRESS 1809 Liberty Grove Rd. 21917	
14. FATHER'S NAME FIRST MIDDLE LAST Elmer Carey Forad				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lily Worthington			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes				16b. SOCIAL SECURITY NO. Karen Confl ick 220-24-2503			
17. INFORMANT ADDRESS Mary Ann Foard (Wife) Same Address							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute coronary insufficiency</i> 4110 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Arteriosclerotic cardiovascular disease</i> (c) <i>Degenerative atherosclerosis</i> DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <i>3-30</i> 19 <i>82</i> , to <i>3-30</i> 19 <i>82</i> , that (I) (we) last saw the deceased alive on <i>3-30</i> 19 <i>82</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.							
22b. SIGNATURE <i>[Signature]</i> DEGREE				22c. DATE SIGNED <i>8/25/83</i>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>H. AMAROWSKI M.D.</i>				22e. ADDRESS <i>318 So. Union Ave. Hdg. Md. 21078</i>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>8-27-1983</i>		23c. NAME OF CEMETERY OR CREMATORY <i>West Nottingham Cem</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Colora Cecil Md.</i>	
24. FUNERAL DIRECTOR NAME <i>[Signature]</i>				25a. DATE REC'D. BY REGISTRAR AND REGISTRAR'S SIGNATURE <i>AUG 29 1983 [Signature]</i>			

100-100000-100000  
100-100000-100000

DATE	DESCRIPTION	AMOUNT	CHECK NO.	INITIALS
10/1/50	100-100000-100000	100.00	100000	
10/2/50	100-100000-100000	100.00	100000	
10/3/50	100-100000-100000	100.00	100000	
10/4/50	100-100000-100000	100.00	100000	
10/5/50	100-100000-100000	100.00	100000	
10/6/50	100-100000-100000	100.00	100000	
10/7/50	100-100000-100000	100.00	100000	
10/8/50	100-100000-100000	100.00	100000	
10/9/50	100-100000-100000	100.00	100000	
10/10/50	100-100000-100000	100.00	100000	
10/11/50	100-100000-100000	100.00	100000	
10/12/50	100-100000-100000	100.00	100000	
10/13/50	100-100000-100000	100.00	100000	
10/14/50	100-100000-100000	100.00	100000	
10/15/50	100-100000-100000	100.00	100000	
10/16/50	100-100000-100000	100.00	100000	
10/17/50	100-100000-100000	100.00	100000	
10/18/50	100-100000-100000	100.00	100000	
10/19/50	100-100000-100000	100.00	100000	
10/20/50	100-100000-100000	100.00	100000	
10/21/50	100-100000-100000	100.00	100000	
10/22/50	100-100000-100000	100.00	100000	
10/23/50	100-100000-100000	100.00	100000	
10/24/50	100-100000-100000	100.00	100000	
10/25/50	100-100000-100000	100.00	100000	
10/26/50	100-100000-100000	100.00	100000	
10/27/50	100-100000-100000	100.00	100000	
10/28/50	100-100000-100000	100.00	100000	
10/29/50	100-100000-100000	100.00	100000	
10/30/50	100-100000-100000	100.00	100000	
10/31/50	100-100000-100000	100.00	100000	

NOTED 10/31/50

100-100000-100000

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

21712

1- FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>John Edward Fox</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>August 22, 1983</b>		2b. HOUR <b>5:00P<sup>M</sup></b>
3. SEX <b>Male</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>May 26 1901</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>82 yrs.</b> YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Cecil</b> MD.	
10. CITY OR TOWN OF DEATH <b>Perry Point</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>V.A.M.C.</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Unknown</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>-----</b>
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Maryland</b>			13b. COUNTY <b>Harford</b>	13c. CITY OR TOWN <b>Aberdeen</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST <b>Unknown</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Unknown</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>10/42-3/43</b>		17. INFORMANT ADDRESS <b>VAMC, Perry Point, Maryland</b>	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardio Respiratory arrest</b> <b>4140</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Arteriosclerotic Heart Disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (c) <b>Chronic obstructive pulmonary disease</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)		

## MEDICAL CERTIFICATION

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>8-11</b> , 19 <b>83</b> , to <b>8-22</b> , 19 <b>83</b> , that (we) lost saw the deceased alive on <b>8-22</b> , 19 <b>83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) <input checked="" type="checkbox"/> view the body after death.			
22b. SIGNATURE <b>VK Nellore</b>	DEGREE <b>MD</b> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>8/22/83</b>
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>VIJAY NELLORE, M.D.</b>		22e. ADDRESS <b>VAMC, Perry Point, Maryland</b>	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>	23b. DATE <b>Aug. 25, 1983</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Oak Lawn Cemetery</b>	23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore Baltimore Maryland</b>
24. FUNERAL DIRECTOR <b>Patterson &amp; Son Funeral Home, Perryville, MD</b>			25a. DATE REC'D. BY REGISTRAR <b>SEP 1 - 1983</b>
			REGISTRAR'S SIGNATURE <b>John J. Connel</b>

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

THE SECRETARY OF THE ARMY  
WASHINGTON, D. C. 20315  
OFFICE OF THE SECRETARY

100-1

August 22, 1947

Joint Army Staff

WILLIAM PATRICK, JR., Major General

August 20, 1947

General Headquarters  
Army of the United States  
Washington, D. C.

WILLIAM PATRICK, JR., Major General

WILLIAM PATRICK, JR., Major General

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of this certificate should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified by item 35.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Isabel Davis George</i>										2a. DATE OF DEATH MONTH DAY YEAR <i>August 12, 1983</i>		2b. HOUR <i>12:17 pm</i>	
3. SEX <i>Female</i>		4. RACE <i>White</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>May 26, 1891</i>		6. AGE (IN YEARS LAST BIRTHDAY) YRS. <i>92</i>		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Cherry Hill Md.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Cecil County</i> MD.							
10. CITY OR TOWN OF DEATH <i>Elkton</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Union Hospital</i>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>School Teacher</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Retired</i>					
13a. STATE <i>Maryland</i>				13b. COUNTY <i>Cecil</i>		13c. CITY OR TOWN <i>North East</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
14. FATHER'S NAME FIRST MIDDLE LAST <i>John H. Davis</i>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Emma Wilson</i>				13e. STREET ADDRESS <i>73 Riverside Drive 21901</i>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i>				16b. SOCIAL SECURITY NO. <i>214-74-4836</i>		17. INFORMANT ADDRESS <i>Mrs. Janith G. Brown 73 Riverside Dr.</i>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: <i>4370 Cardio Respirator Arrest</i> DUE TO, OR AS A CONSEQUENCE OF (a) <i>Cerebral Failure</i> (b) <i>Generalized Atherosclerosis</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Generalized Atherosclerosis</i> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <i>None</i>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <i>Dec 19 1962</i> to <i>Aug 12 1983</i> , that (I) (we) lost saw the deceased alive on <i>Aug 12 1983</i> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body (bodies) directly.													
22b. SIGNATURE <i>Joseph G. Lanzi</i>				DEGREE <i>MD</i>				22c. DATE SIGNED <i>Aug 17 1983</i>					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Joseph G. Lanzi</i>				22e. ADDRESS <i>721 Bridge St. Elkton, Maryland</i>									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>				23b. DATE <i>Aug. 16, 1983</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Cherry Hill Cemetery</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Cherry Hill Cecil Maryland</i>					
24. FUNERAL DIRECTOR <i>Gee Funeral Home</i>				25a. DATE REC'D BY REGISTRAR <i>AUG 17 1983</i>				25b. REGISTRAR'S SIGNATURE <i>John J. Lanzi</i>					

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*[Faint, mostly illegible text and markings, possibly bleed-through from the reverse side of the page. Some faint words like "Carbon" and "copy" are visible.]*

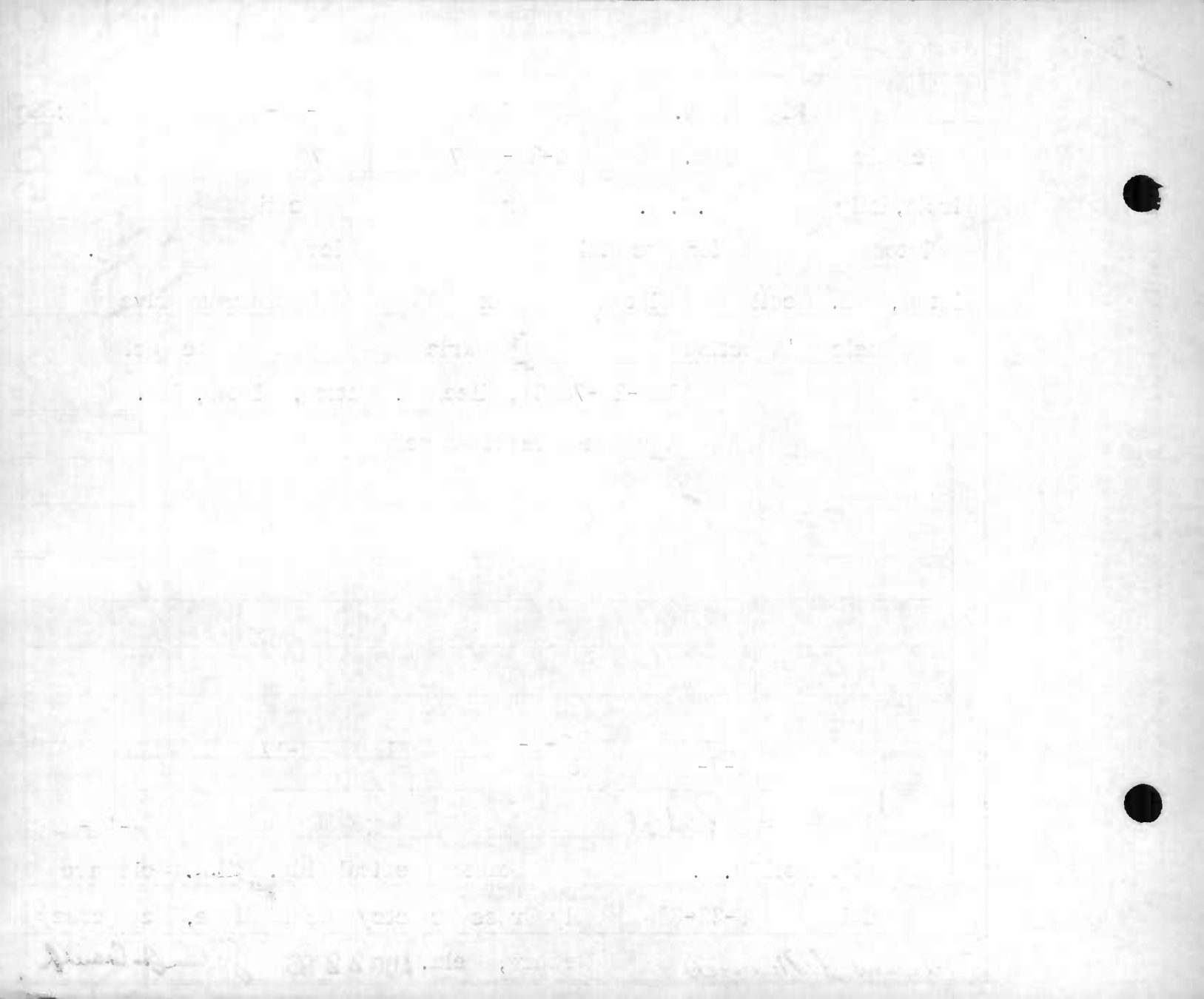
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of one.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		21714 REG. NO.							
1. DECEASED NAME (TYPE OR PRINT) MARIE A. GERMUSKA					2a. DATE OF DEATH MONTH DAY YEAR 8-17-1983			2b. HOUR 11:50p <sub>M</sub>	
3 SEX Female		4 RACE Cauc.		5 DATE OF BIRTH MONTH DAY YEAR 6-25-1907		6 AGE (IN YEARS LAST BIRTHDAY) 76 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Airolo, Italy		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Cecil MD.			
10. CITY OR TOWN OF DEATH Elkton		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Union Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Clerk		12b. KIND OF BUSINESS OR INDUSTRY Mfg.	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE 13b. CITY OR TOWN 13c. INSIDE CITY LIMITS? Elkton, Md. Cecil Elkton YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					13d. STREET ADDRESS 17 Locharron Drive 21921				
14 FATHER'S NAME FIRST MIDDLE LAST Raffaele D'Agostino					15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Marie KeMasi				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 138-26-7532		17 INFORMANT ADDRESS Eileen G. Matthey, Elkton, Md.					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Advanced Breast Cancer 1749 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) _____ (c) _____ DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 2-3-1981 to 8-17-1983, that (I) (we) last saw the deceased alive on 8-7-1983, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Yogist A. Patel				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 8-19-83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Yogist Patel M.D.				22e. ADDRESS Stanton Medical Bldg. Wilm. Delaware					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 8-22-83		23c. NAME OF CEMETERY OR CREMATORY Holy Cross Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Baskin Ridge, New Jersey			
24. FUNERAL DIRECTOR NAME Freeman J. Hawick				ADDRESS Newark, Dela.		25a. DATE REC'D. BY REGISTRAR AUG 22 1983		25b. REGISTRAR'S SIGNATURE John J. Canale	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.	
1. FOR STATE REGISTRAR						21715					
1. DECEASED NAME (TYPE OR PRINT) <b>John I. Grant, SR.</b>						2a. DATE OF DEATH MONTH DAY YEAR <b>AUGUST 19, 1983</b>				2b. HOUR <b>P.M.</b>	
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>SEPT. 13, 1906</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>76</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Cecil</b> MD.					
10. CITY OR TOWN OF DEATH <b>Elkton</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Union Hospital</b>						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Maintenance-Union Hospital</b>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Cecil</b>		13c. CITY OR TOWN <b>Elkton</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>214 E. Main Street</b>		13f. CITY OR TOWN <b>21921</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Arthur E. Grant</b>						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Agnes - timmons</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>						16b. SOCIAL SECURITY NO. <b>717-07-5358</b>		17. INFORMANT ADDRESS <b>Mrs. Bertha H. Grant, Elkton, Md. 21921</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardio Respiratory Arrest</b> <b>1611</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Dehydration + Malnutrition</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Metastatic Esophogeal Cancer</b> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>8/19/83</b> to <b>8/19/83</b> , that (I) (we) lost saw the deceased alive on <b>8/19/83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>Joseph G. Lanzi, M.D.</b>				DEGREE <b>M.D.</b>				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>8-19-83</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Joseph G. Lanzi, M.D.</b>				22e. ADDRESS <b>721 Bridge Street, Elkton, Md. 21921</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>				23b. DATE <b>8-22-83</b>		23c. NAME OF CEMETERY OR CREMATORY <b>North East Methodist Cemetery, North East, Md. 21901</b>		23d. LOCATION CITY OR TOWN COUNTY STATE			
24. FUNERAL DIRECTOR <b>Ralph E. Hicks</b> ADDRESS <b>HICKS HOME FOR FUNERALS, ELKTON, MD. 21921</b>						25a. DATE REC'D. BY REGISTRAR <b>AUG 25 1983</b> 25b. REGISTRAR'S SIGNATURE <b>John J. Carver</b>					



Page 1 of 1

1. Name: [illegible]  
2. Address: [illegible]  
3. City: [illegible]  
4. State: [illegible]  
5. Zip: [illegible]  
6. Phone: [illegible]  
7. Email: [illegible]  
8. Date: [illegible]  
9. Signature: [illegible]  
10. Title: [illegible]

[Large handwritten signature across the middle of the page]

11. Date: [illegible]  
12. Signature: [illegible]  
13. Title: [illegible]  
14. Date: [illegible]  
15. Signature: [illegible]  
16. Title: [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 22 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 21716			
1. FOR STATE REGISTRAR				2. DATE OF DEATH MONTH DAY YEAR 2b HOUR			
1. DECEASED NAME FIRST MIDDLE LAST JAMES L. HALL JR.				August 23, 1983 11:25PM			
3. SEX M		4. RACE B		5. DATE OF BIRTH MONTH DAY YEAR 7 27 15		6. AGE (IN YEARS LAST BIRTHDAY) 68 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Cecil MD.	
10. CITY OR TOWN OF DEATH Perry Point		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) VA Medical Center Perry Point, MD		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY Railroad	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE 13c. CITY OR TOWN 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> 13e. STREET ADDRESS				600 Green Street 21078			
14. FATHER'S NAME FIRST MIDDLE LAST				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes				16b. SOCIAL SECURITY NO. 218-05-0860			
17. INFORMANT ADDRESS Mary Allender 401 Webb Lane HDG, MD.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)							
PART I. DEATH WAS CAUSED BY:							
IMMEDIATE CAUSE (a) Respiratory Arrest							
1850 DUE TO, OR AS A CONSEQUENCE OF (b) Carcinoma of Prostate with Metastasis							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (c)							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (this hospital) attended the deceased from Jul 13, 19 83, to Aug 23, 19 83, that (he)(we) last saw the deceased alive on Aug 23, 19 83, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Prem Lal, M.D.				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 8-24-83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) PREM LAL, M.D.				22e. ADDRESS VA Medical Center Perry Point, MD			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 8/26/83		23c. NAME OF CEMETERY OR CREMATORY St. James Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE HavreDeGrace Harford Md.	
24. FUNERAL DIRECTOR NAME ADDRESS ARNOLD W. BEARD FUNERAL HOME, HAVRE DE GRACE, MD				25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE SEP 8 1983 John J. Connel			

BP



STATE OF MARYLAND  
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
 CERTIFICATE OF DEATH

REG. NO.

 FOR  
 1 - STATE  
 REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Anna B. Holloway</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>8/21/83</i>		2b. HOUR MIN. <i>9:30</i> <sup>P</sup>				
3. SEX <i>Female</i>		4. RACE <i>White</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>Aug. 17, 1901</i>		6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS HOURS MIN. <i>82</i> YRS.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Penna.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Cecil Co</i> MD.			
10. CITY OR TOWN OF DEATH <i>Elkton</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Union Hospital</i>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Housewife</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>at home</i>		
13a. STATE <i>Pa.</i>		13b. COUNTY <i>Del.</i>		13c. CITY OR TOWN <i>Drexel Hill</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <i>1108 Harper Avenue 99999</i>	
14. FATHER'S NAME FIRST MIDDLE LAST <i>John Jones</i>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Jennie Cunningham</i>			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <i>no</i>		16b. SOCIAL SECURITY NO. <i>174-50-4349</i>	
17. INFORMANT <i>Nelson Holloway</i>			ADDRESS <i>1108 Harper Ave., Drexel Hill, Pa.</i>						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiorespiratory arrest</i> <i>1629</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Cancer Lung, metastatic</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>arteriosclerotic heart disease</i>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <i>no</i>									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (the undersigned) attended the deceased from <i>July</i> 19 <i>81</i> , to <i>August 21,</i> 19 <i>83</i> , that (I) (we) last saw the deceased alive on <i>August 21,</i> 19 <i>83</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.									
22b. SIGNATURE <i>Jolann Rosenfeld mo</i>			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <i>8/22/83</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Jo Anne Rosenfeld, M.D.</i>			22e. ADDRESS <i>Cecilton, Md.</i>						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>			23b. DATE <i>8-26-83</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Holy Cross Cem.</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Yeadon Del. Pa.</i>		
24. FUNERAL DIRECTOR NAME <i>SEE FUNERAL HOME, Pa.</i>			24b. CITY OR TOWN <i>Elkton, Md.</i>		25a. DATE REC'D BY REGISTRAR <i>AUG 26 1983</i>				

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrars, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1- FOR STATE REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>ERNEST PRESTON HOWERY</b>			2a. DATE OF DEATH MONTH <b>August</b> DAY <b>31</b> YEAR <b>1983</b>		2b. HOUR <b>2:17 p.m.</b>
3. SEX <b>Male</b>	4. RACE <b>White</b>	5. DATE OF BIRTH <b>Jan. 18 1927</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>56</b>	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN) <b>Maryland</b>	7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Cecil County</b> MD.	
10. CITY OR TOWN OF DEATH <b>Perry Point</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>VA Medical Center</b>		12a. USUAL OCCUPATION (IF NOT WORKING, GIVE WORKING LIFE) <b>Salesman</b>		12b. KIND OF BUSINESS OR INDUSTRY
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Penna.</b> 13b. COUNTY <b>Chester</b> 13c. CITY OR TOWN <b>Oxford</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>2150 Barnsley-Chrome Rd.</b>	
14. FATHER'S NAME FIRST <b>Ernest</b> MIDDLE <b>Preston</b> LAST <b>Howery</b>		15. MOTHER'S MAIDEN NAME FIRST <b>Ada</b> MIDDLE <b>Calvert</b> LAST			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>yes</b> <b>WWII</b>		16b. SOCIAL SECURITY NO. <b>202-18-0252</b>		17. INFORMANT ADDRESS <b>Therese Howery Oxford, Pa. 19363</b>	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac Arrest</b> <b>4289</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Cardiac Failure</b> DUE TO, OR AS A CONSEQUENCE OF (c)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
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PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	

22a. I certify that (I) (this hospital) attended the deceased from **August 31 1983** to **August 31 1983** **XXXXXXXX**  
and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE <b>Abdul Karim</b>	DEGREE <b>MD</b>	ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>	22c. DATE SIGNED <b>8-31-83</b>
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>ABDUL KARIM, M.D.</b>		22e. ADDRESS <b>VAMC, Perry Point, MD</b>	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>	23b. DATE <b>9-3-1983</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Oxford Cem.</b>	23d. LOCATION CITY OR TOWN COUNTY STATE <b>Oxford Chester Penna</b>
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24. FUNERAL DIRECTOR <b>R.T. Hoard</b>	25a. DATE REC'D. BY REGISTRAR <b>SEP 8 1983</b>	25b. REGISTRAR'S SIGNATURE <b>John J. Covich</b>
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed without delay after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be called to examine the body.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.	
1. FOR STATE REGISTRAR					
1. DECEASED NAME (TYPE OR PRINT) <b>Clarence H. Juergens</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>August 13, 1983</b>		2b. HOUR <b>1:15A</b> M
3 SEX <b>Male</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>May 17, 1905</b>	6. AGE (IN YEARS LAST BIRTHDAY) <b>78</b> YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>W. Virginia</b>	7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH <b>Cecil</b> MD.		
10. CITY OR TOWN OF DEATH <b>Perry Point, Md.</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN U.S. CITY, GIVE STREET ADDRESS) <b>VA Medical Center 21092</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Chef</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Navy</b>
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Maryland</b>			13b. COUNTY <b>Harford</b>	13c. CITY OR TOWN <b>Aberdeen</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST <b>Leopold Juergens</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Etta Rogers</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>YES</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>WW II</b>	17. INFORMANT ADDRESS <b>VAMC, Perry Point, Maryland</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: <b>5789</b> IMMEDIATE CAUSE (a) <b>Gastrointestinal bleeding, acute, site undetermined</b>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
DUE TO, OR AS A CONSEQUENCE OF (b) _____					
DUE TO, OR AS A CONSEQUENCE OF (c) _____					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B. PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>8-11-</b> 19 <b>83</b> , to <b>8-13-</b> 19 <b>83</b> , that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on <b>8-13-</b> 19 <b>83</b> , and that <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) (not) view the body after death.					
22b. SIGNATURE <i>M. N. Atay</i> DEGREE				22c. DATE SIGNED <b>8-15-83</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>M. N. ATAY, M.D.</b>				22e. ADDRESS <b>VA Medical Center, Perry Point, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Removal/Burial</b>		23b. DATE <b>Aug 19, 1983</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Richwood Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Richwood Nicholas W. VA</b>
24. FUNERAL DIRECTOR NAME <b>Tarring Funeral Home, Aberdeen, Md.</b>		ADDRESS <b>21001-3399</b>		25a. DATE REC'D. BY REGISTRAR <b>AUG 23 1983</b>	
		25b. REGISTRAR'S SIGNATURE <i>John J. Carver</i>			

BP

Clarence H. Jackson

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 48 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of the death.

1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			2a. DATE OF DEATH			2b. HOUR		
FIRST MIDDLE LAST ROBERT F. KING			MONTH DAY YEAR AUGUST 7, 1983			4:15p M		
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR		8. IF UNDER 24 HRS.
Male	White	MONTH DAY YEAR NOVEMBER 6, 1917		65 YRS.		MONTHS DAYS		HOURS MIN
9a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	9b. CITIZEN OF WHAT COUNTRY?	10. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH				
New York	USA			Cecil MD.				
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY	
Elkton	Union Hospital			Management Analyst			St. Bainbridge	
13a. STATE								
13b. COUNTY			13c. CITY OR TOWN			13d. STREET ADDRESS		
Maryland			Cecil			North East		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME			16. ADDRESS		
FIRST MIDDLE LAST James Francis King			FIRST MIDDLE LAST Irene - Smith					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)			17. INFORMANT		
Yes			WW 2			088-07-1845A		
						Mrs. Virginia D. King, North East, Md. 21901		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Aspiration pneumonia</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Cef. large</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u></u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
						June 1981		
22a. I certify that (I) (this hospital) attended the deceased from <u>June 1981</u> to <u>August 1983</u> , that (I) (we) last saw the deceased alive on <u>8-3-1983</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE <u>Dr. Siamak Samii</u>						22c. DATE SIGNED 8-8-83		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Siamak Samii						22e. ADDRESS Carpenter Clinic, Wilmington, Del.		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY		
Burial			8-10-83			Immaculate Conception Cemetery, Cherry Hill, Md.		
24. FUNERAL DIRECTOR HICKY HOME FOR FUNERALS, ELKTON, MD. 21921			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE		
			AUG 19 1983			John E. C...		

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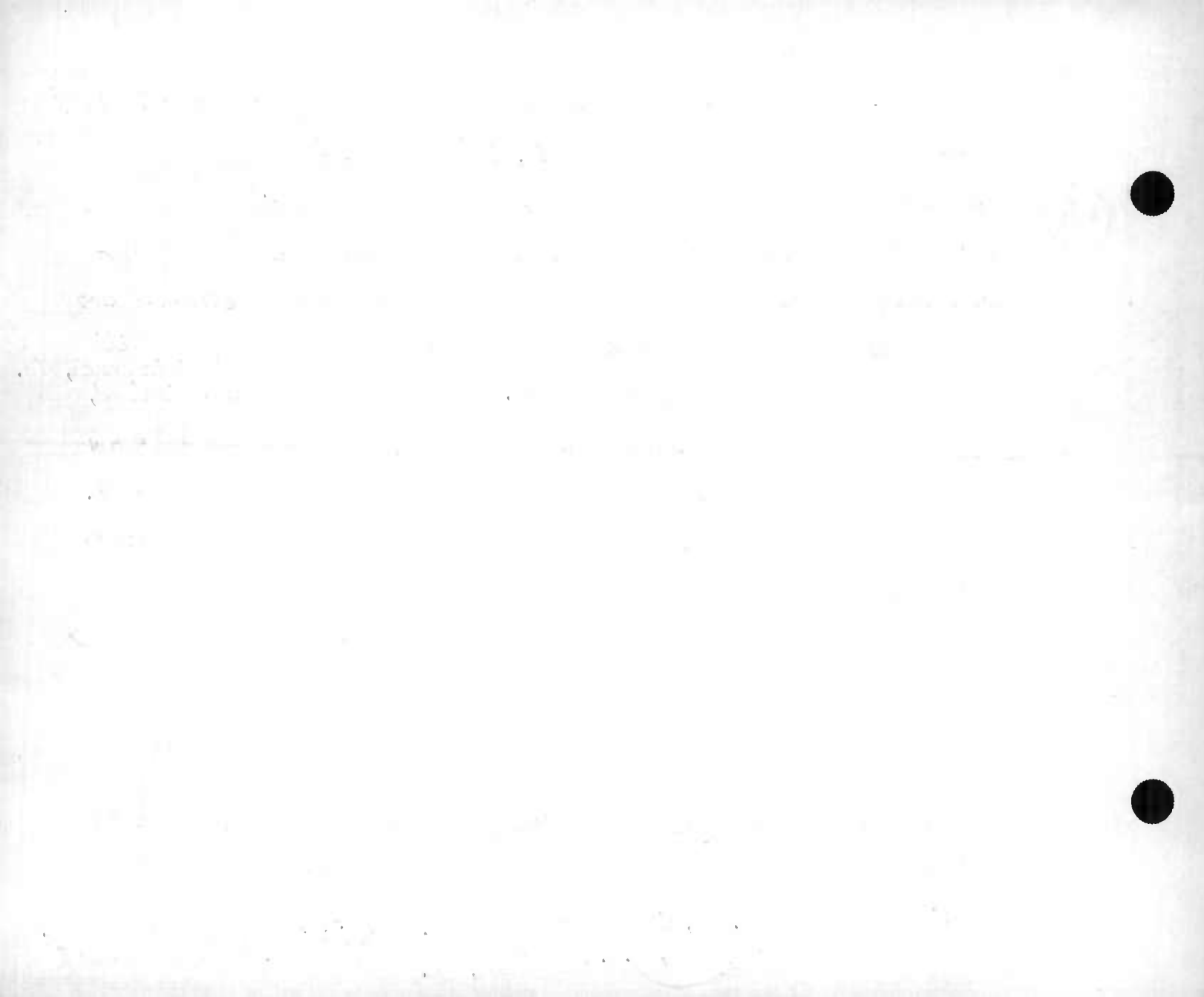
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed in the office of the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		REG. NO.		21721					
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ROSE M LARAMORE				2a. DATE OF DEATH MONTH DAY YEAR 8 19 83		2b. HOUR 11:05 P.M.			
3. SEX FEMALE		4. RACE CAUC		5. DATE OF BIRTH MONTH DAY YEAR May 10, 1898		6. AGE (IN YEARS LAST BIRTHDAY) 85 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) DELAWARE		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Cecil MD.			
10. CITY OR TOWN OF DEATH ELKTON, MD.		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) UNION HOSPITAL OF CECIL COUNTY				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE		12b. KIND OF BUSINESS OR INDUSTRY N/A	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MARYLAND				13b. COUNTY CECIL		13c. CITY OR TOWN NORTH EAST		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Thomas				15. MOTHER'S MAIDEN NAME FIRST MIDDLE Anna Dill		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no			
16b. SOCIAL SECURITY NO. none				17. INFORMANT ADDRESS Virginia Beach, Va. Mrs. Charles Gates 5560 Wm. Admiral Rd.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 2390 ASPIRATION (b) GASTROINTESTINAL BLEEDING (c) GASTRIC TUMOR								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 MIN 6 HR. YEARS	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): ADVANCED AGE									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22. I certify that (I) (this hospital) attended the deceased from AUG. 19, 19 83, to AUG 19, 19 83, that (I) (we) lost saw the deceased alive on AUG 19, 19 83, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Andrew P. Fridberg MD				DEGREE MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 8/14/83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ANDREW FRIDBERG MD				22e. ADDRESS 639 Aikin Ave. PERRYVILLE, MD. 21903					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Aug. 23, 1983		23c. NAME OF CEMETERY OR CREMATORY Charlestown Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Charlestown Cecil Md.		23e. DATE REC'D. BY REGISTRAR AUG 26 1983	
24. FUNERAL DIRECTOR NAME SEE FUNERAL HOME ADDRESS Elkton, Md.				25. REGISTRAR'S SIGNATURE John J. Smith					

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

21722

1. FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>Kenneth O. Lee</b>		2a. DATE OF DEATH MONTH DAY YEAR <b>August 28, 1983</b>		2b. HOUR A M <b>5:15</b>	
3. SEX <b>Male</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>Dec. 6, 1924</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>58</b> YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Oklahoma</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Cecil</b> MD.	
10. CITY OR TOWN OF DEATH <b>Perry Point</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Perry Point V.A. Med. Cen.</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Production Sup.</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Ind.</b>
13a. STATE <b>Md.</b>		13b. COUNTY <b>Cecil</b>	13c. CITY OR TOWN <b>Perryville</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS <b>1524 Carpenters Rd.</b>
14. FATHER'S NAME FIRST MIDDLE LAST <b>George Lee</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Lucinda Davis</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. <b>448 14 6212</b>		17. INFORMANT ADDRESS <b>VAMC, Perry Point, Maryland</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Terminal metastasis of carcinoma of the lung</b> 1629 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (X) this hospital attended the deceased from <b>8-4-83</b> to <b>8-28-83</b> , that (X) (we) last saw the deceased alive on <b>8-28-83</b> , and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above, (b) (we) did not view the body after death.					
22b. SIGNATURE <b>K. Rothbaum MD.</b>		DEGREE <b>MD.</b>		22c. DATE SIGNED <b>8-28-83</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>KENNETH ROTHBAUM, M.D.</b>		22e. ADDRESS <b>VAMC, Perry Point, Maryland</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>8-31-83</b>		23c. NAME OF CEMETERY OR CREMATORY <b>St. Mary Anne's</b>	
23d. LOCATION (CITY OR TOWN) <b>North East Cecil Md.</b>		23e. STATE <b>Md.</b>		23f. DATE REC'D. BY REGISTRAR <b>SEP 1 1983</b>	
24. FUNERAL DIRECTOR NAME <b>Crouch Funeral Home</b>		ADDRESS <b>127 S. Main St., North East</b>		25. REGISTRAR'S SIGNATURE <b>John J. Carney</b>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death and returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of same.



RECEIVED  
JAN 10 1964  
U.S. AIR FORCE  
HONOLULU, HAWAII

U.S. AIR FORCE  
HONOLULU, HAWAII

U.S. AIR FORCE  
HONOLULU, HAWAII

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

FOR  
1 - STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>Howard P. Logan</b>			2a. DATE OF DEATH MONTH <b>8</b> DAY <b>27</b> YEAR <b>83</b>			2b. HOUR <b>4:15 PM</b>			
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH <b>Oct.</b> DAY <b>4</b> YEAR <b>1905</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>77</b> YRS.		IF UNDER 1 YEAR MONTHS <b>77</b> DAYS <b>77</b> HOURS <b>77</b> MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Penn.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Cecil</b> MD.			
10. CITY OR TOWN OF DEATH <b>ELKTON</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Union Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Self-employed</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Real Estate</b>	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) <b>MD.</b>			13b. COUNTY <b>Cecil</b>		13c. CITY OR TOWN <b>North East</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14. FATHER'S NAME <b>John P. Logan</b>			15. MOTHER'S MAIDEN NAME <b>Helen Elizabeth Hague</b>			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> OR UNKNOWN)			
16b. SOCIAL SECURITY NO. <b>220-05-5850</b>			17. INFORMANT <b>Elizabeth Logan</b>			ADDRESS <b>320 Bailiff Rd. North East, Md. 21901</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>PNEUMONIA</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Chronic obstructive Lung Disease</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>4960</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>about 24 hrs</b> <b>years</b>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>Arteriosclerotic Cardiovascular Disease, Anemia</b>									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>July</b> 19 <b>79</b> , to <b>August 27</b> 19 <b>83</b> , that (I) (we) last saw the deceased alive on <b>August 28</b> 19 <b>83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>Charles m. Hensgen</b>			DEGREE <b>MD</b>			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>8-31-83</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Charles m. Hensgen</b>			22e. ADDRESS <b>3 manlin Avenue, North East, md</b>						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>8-30-83</b>		23c. NAME OF CEMETERY OR CREMATORY <b>North East Meth. Cem.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>North East Cecil Md.</b>		
24. FUNERAL DIRECTOR NAME <b>Crown Funeral Home</b>			ADDRESS <b>North East, Md.</b>			25. DATE REC'D. BY REGISTRAR <b>SEP 2 - 1983</b>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



11/11/11

80% CO

Handwritten notes and text, mostly illegible due to blurriness and bleed-through. Visible fragments include:  
- "Howard P. Ingram" (top center)  
- "Cecil" (middle left)  
- "11/11/11" (center)  
- "80% CO" (center)  
- "M D" (center, part of logo)  
- "The above is a true and correct copy of the original" (bottom left, faint)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.			
1. FOR STATE REGISTRAR				2a. DATE OF DEATH MONTH DAY YEAR			
1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Okie Lillian Marshall				August 16, 1983			
3 SEX Female		4 RACE White		5 DATE OF BIRTH MONTH DAY YEAR Sept. 24 1920		6 AGE (IN YEARS LAST BIRTHDAY) YRS. 62	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) W. Va.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Cecil MD.	
10 CITY OR TOWN OF DEATH Elkton		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Union Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Home	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				13a. STATE 13b. COUNTY 13c. CITY OR TOWN			
13a. Md. 13b. Cecil 13c. Charlestown				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
14 FATHER'S NAME FIRST MIDDLE LAST Walter Murphy				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Celia Lester			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO 232-56-9242		17 INFORMANT ADDRESS John Marshall P.O. Box 95 Charlestown, Md. 21914			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>Acute myocardial Infarction.</u> 4100 DUE TO, OR AS A CONSEQUENCE OF (b) <u>General arteriosclerotic vascular disease.</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>COPD Emphysema, pneumonia CHF.</u>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION CITY OR TOWN COUNTY STATE			
22a. I certify that (X) this hospital attended the deceased from 8/16 1983, to 8/16 1983, that (X) (we) lost saw the deceased alive on 8/16 1983, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (If we did not view the body after death.)							
22b. SIGNATURE Jui-Chih Hsu				DEGREE MD		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Jui-Chih Hsu, MD. PA.				22e. ADDRESS 223 W. Main St. Elkton, Md. 21921			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 8-20-83		23c. NAME OF CEMETERY OR CREMATORY North East Meth.		23d. LOCATION CITY OR TOWN COUNTY STATE North East Cecil Md.	
24 FUNERAL DIRECTOR NAME Crouch Funeral Home North East, Md.				25a. DATE REC'D. BY REGISTRAR AUG 23 1983		25b. REGISTRAR'S SIGNATURE John J. Lohr	

1550

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		2a. DATE OF DEATH MONTH DAY YEAR				2b. HOUR			
1. DECEASED NAME (TYPE OR PRINT)		2a. DATE OF DEATH MONTH DAY YEAR				2b. HOUR			
Waverly Floyd Melton		August 3, 1983				7:30 MA.			
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS	
Male	White	Aug. 23 1896		86		MONTHS DAYS		HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
Virginia	U.S.A.			Cecil MD.					
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY		
Elkton	Union Hospital			Accountant			Exxon		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a. 5148 13b. Cecil 13c. North East									
14. FATHER'S NAME FIRST MIDDLE LAST					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST				
Unknown					Sarah Blackburn				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE YEAR OF DATES)		17. INFORMANT ADDRESS					
Yes		170-09-1309		Nell Melton 400 Rolling Mill Rd. North East, Md. 21901					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a). 4029 Cardiovascular & Respiratory Failure DUE TO, OR AS A CONSEQUENCE OF (b). Cardiac Arrest Not responded to CPR DUE TO, OR AS A CONSEQUENCE OF (c). Hypertension with H.C.V.D. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a). G.I.S. with A.S.E.V.D.; Severe C.O.P.D.; Chronic C.H.F.; J.T.A.									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from Jan. 4 - 1966 to Aug. 3, 1983, that (I) (we) lost saw the deceased alive on Nov 11, 1982, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (each) (did not) view the body after death.									
22b. SIGNATURE		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED			
LUIS M. CUZA		M.D.				8-3-83			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS							
LUIS M. CUZA		M.D.		322 E Cecil Ave. North East Md 21901					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE			
Cremation		August 4, 1983		Cratin & Ferris W. Chester		Chester Pa.			
24. FUNERAL DIRECTOR NAME		24b. ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
C. J. ...		Home North East, Md.		AUG 8 1983		John J. ...			

101

1000 ft. above sea level  
1000 ft. above sea level  
1000 ft. above sea level

A. L. T. 1000 ft. above sea level

1000 ft. above sea level

1000 ft. above sea level

1000 ft. above sea level

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

1. FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Joseph E Mendenhall			2a. DATE OF DEATH MONTH DAY YEAR 8 26 83		2b. HOUR 3:40 AM
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR 2 27 99	6. AGE (IN YEARS LAST BIRTHDAY) 84 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Cecil MD.		
10. CITY OR TOWN OF DEATH Rising Sun	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Calvert Manor Nursing Home		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Farmer	12b. KIND OF BUSINESS OR INDUSTRY Farming	
13a. STATE Md.		13b. COUNTY Cecil	13c. CITY OR TOWN Perryville	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS R.D. #1, Box 451
14. FATHER'S NAME FIRST MIDDLE LAST Abraham Cecil Mendenhall		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Norah Yerkes			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) UNKNOWN		16b. SOCIAL SECURITY NO. 218-36-2792A	17. INFORMANT Alice Mendenhall Rd. #1 Box 451 Perryville, Md.		
18. CAUSE OF DEATH PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction 4100 DUE TO, OR AS A CONSEQUENCE OF (b) Coronary Insufficiency DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 days 5 yrs.					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 8-1-80 to 8-25-83, that (I) (we) last saw the deceased alive on 8-25-83, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Neil R. Taylor MD		DEGREE MD		22c. DATE SIGNED 8-26-83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Neil R. Taylor Jr MD		22e. ADDRESS Rising Sun, Md			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL	23b. DATE 8/28/83	23c. NAME OF CEMETERY OR CREMATORY ROSE BANK		23d. LOCATION CITY OR TOWN COUNTY STATE CAULWAT CEUL MD.	
24. FUNERAL DIRECTOR NAME Richard L. Goodie		ADDRESS Rising Sun, Md		25a. DATE REC'D. BY REGISTRAR AUG 29 1983	
				25b. REGISTRAR'S SIGNATURE John A. B... ..	

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

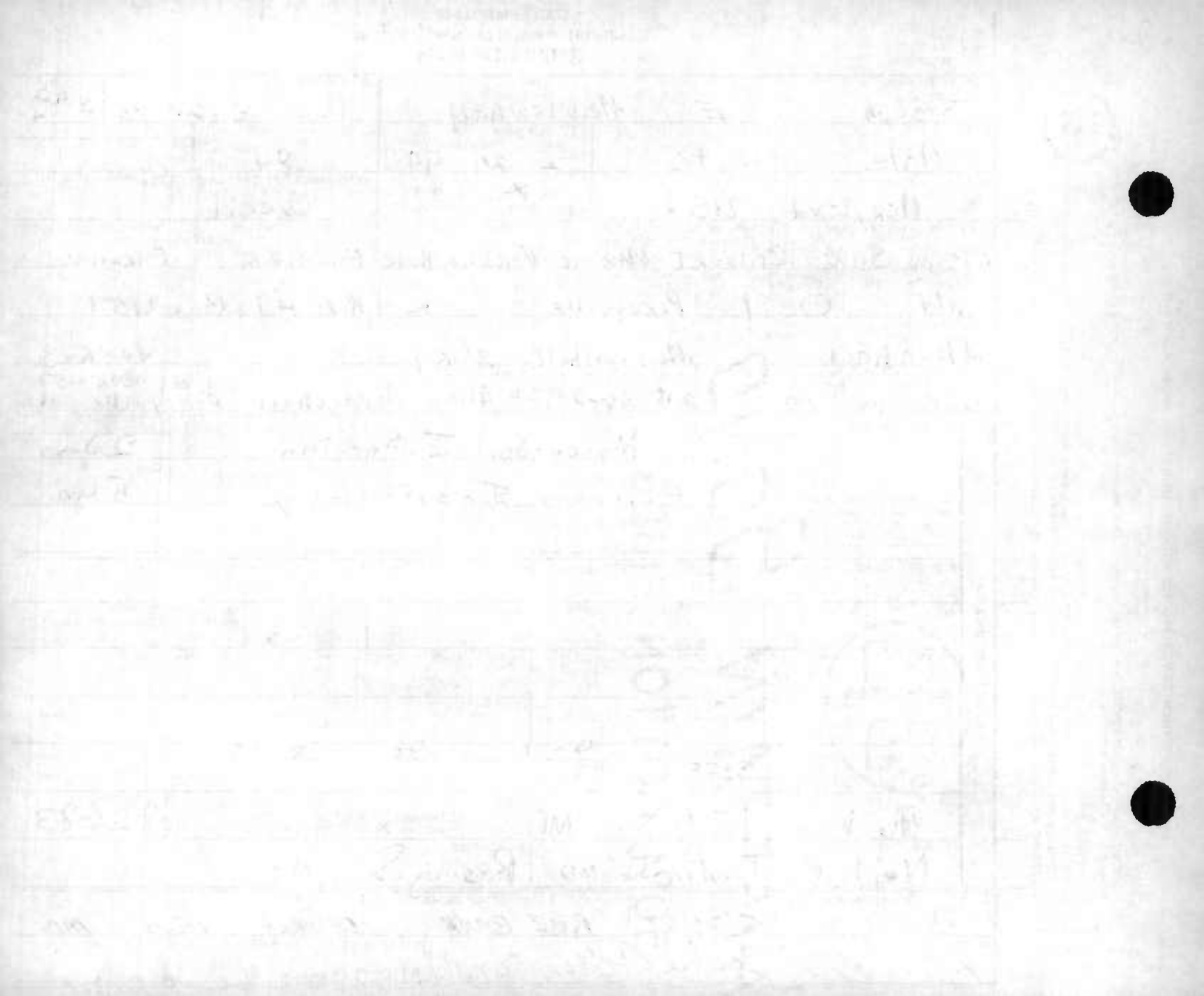
MEDICAL CERTIFICATION

BP

DHMH - 16 50M 1/76  
(VR A 15 (4))

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

83 2 1 7 2 7

1- FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE KNOWN OF DEATH		ESTIMATED		MONTH		DAY		YEAR		2b. HOUR	
BERTHA		M.		MOORE				8		7		19		83				A. M.	
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 1 YR.		IF UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD		MONTH		DAY		YEAR		2d. HOUR	
Female	White	DEC. 19, 1900		82 YRS.						8		7		19		83		A. M.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED		NEVER MARRIED		9. BALTIMORE CITY OR COUNTY OF DEATH											
Delaware		USA		WIDOWED		DIVORCED		Cecil											
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY													
Elkton		Union Hospital		Homemaker															
13a. STATE		13b. CITY OR TOWN		13c. INSIDE CITY LIMITS?		13d. STREET ADDRESS													
Maryland		Cecil		Elkton		YES		230 East Main Street		21921									
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME																	
Ernest		Brown		Elva		Drummond													
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS													
No		219-36-0182		Mrs. B. Mildred Null, Elkton, Md.		21921													
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Heart Failure</u> <u>4292</u> Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last. (b) <u>ASCVD</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u></u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 hr</u>																	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).																			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?															
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)															
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE															
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .		ACTUAL SIGNATURE <u>Ernest W. Seiter MD</u>		TITLE (SPECIFY) M.D. <u>RISING SUN MD. 21911</u>		MEDICAL EXAMINER		DATE SIGNED <u>Aug 7, 1983</u>											
EXAMINER'S NAME (TYPE OR PRINT) <u>ERNEST W. SEITER MD</u>		ADDRESS <u>RISING SUN MD. 21911</u>																	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE													
Burial		8-10-83		Cherry Hill Cemetery		Cherry Hill, Maryland													
24. FUNERAL DIRECTOR NAME <u>Ralph E. Hicks</u>		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE															
HICKS HOME FOR FUNERALS, ELKTON, MD. 21921		AUG 19 1983		John J. Carver															

MEDICAL CERTIFICATION



NOTION 1381

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		MONTH DAY YEAR		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		August 25, 1983		6:00A M	
Lester D. Myers							
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)	
Male		White		August 9, 1892		91 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH	
Pennsylvania		USA				Cecil County MD	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Perry Point, Md.		VA Medical Center 21092		Machanic			
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?	
Pennsylvania		Huntingdon		Dudley		YES <input type="checkbox"/> UNK <input type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		13e. STREET ADDRESS		99999	
FIRST MIDDLE LAST		FIRST MIDDLE LAST		UNK			
UNKNOWN		UNKNOWN					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT		ADDRESS	
YES		WW I		218 54 0483		VAMC, Perry Point, Maryland 21092	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		PART I. DEATH WAS CAUSED BY:		IMMEDIATE CAUSE (a)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
4920		Cardiopulmonary arrest				30 minutes	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		(b) Pneumonia- multi-lobed				1 week	
		(c) Emphysema				20 years	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)		Leukopenia and Diabetes					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART I OR PART 2)			
		P.M. 19					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 2-7-80, to 8-25-83, that (we) lost the deceased alive on 8-25-83, and that in (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (not) view the body after death.		22b. SIGNATURE		DEGREE		22c. DATE SIGNED	
		William Rennie		MO		8-25-83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			
WILLIAM A. RENIE, M.D.		VAMC, Perry Point, Maryland					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE	
Burial		Aug. 30, 1983		Culpepper Nat'l. Cem.		Culpepper Culpepper VA	
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Tarring Funeral Home, Aberdeen, Md.		21001-3399		AUG 29 1983		John J. Carish	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be called and advised.STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. FOR STATE REGISTRAR		2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR	
1. DECEASED NAME FIRST MIDDLE LAST Harvey L. Newton, SR		08-14-83		8:55A <sub>M</sub>	
3 SEX Male	4 RACE Caucasian	5. DATE OF BIRTH MONTH DAY YEAR 09 13 19	6 AGE (IN YEARS LAST BIRTHDAY) 63 YRS	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN) Delaware	7b. CITIZEN OF WHAT COUNTRY? USA	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9 BALTIMORE CITY OR COUNTY OF DEATH Cecil County MD		
10 CITY OR TOWN OF DEATH Elkton	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Union Hospital		12a. USUAL OCCUPATION (IF WORK FOR MOST OF WORKING LIFE) Home Builder		
13a. STATE Delaware	13b. COUNTY N.C.	13c. CITY OR TOWN Middletown	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14 FATHER'S NAME John	15. MOTHER'S MAIDEN NAME Iva Robbins	13e. STREET ADDRESS A.D. 2. BOX 129 9999			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (IF YES, GIVE WAR OR DATE) Yes	16b. SOCIAL SECURITY NO. W.W. II 222-01-1317	17 INFORMANT Madelon M. Newton, Middletown, Md			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: 4100 IMMEDIATE CAUSE (a) Acute Myocardial Infarct DUE TO, OR AS A CONSEQUENCE OF (b) Generalized Atherosclerosis DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1; OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from June 6, 1960, to 8/14, 1983, that (we) lost saw the deceased alive on 8/13, 1983, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Joseph G. LANZI		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 8/14/83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Joseph G. LANZI		22e. ADDRESS Union Hospital/Cecil Co., Elkton, Md			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 8/17/83		23c. NAME OF CEMETERY OR CREMATORY Oak Hill Cem	
23d. LOCATION Annapolis Md		23e. DATE REC'D. BY REGISTRAR AUG 17 1983			
24. FUNERAL DIRECTOR Robert C. Hutchinson		25b. REGISTRAR'S SIGNATURE John J. Canine			



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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)			2a. DATE OF DEATH			2b. HOUR		
FRANK <i>Nicholas</i> PANOS			AUGUST 5 1983			4:15P M		
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)			7. IF UNDER 1 YEAR		
MALE	White	JUNE 13, 1919	64 YRS.			MONTHS DAYS HOURS MIN.		
8. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	9. BALTIMORE CITY OR COUNTY OF DEATH	10. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION						
Bel Air Maryland	Cecil County, MD.	VA HOSPITAL PERRY POINT, MD						
11. CITY OR TOWN OF DEATH	12a. USUAL OCCUPATION	12b. KIND OF BUSINESS OR INDUSTRY						
Perry Point	OWNER	Restaurant						
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?			13e. STREET ADDRESS		
Maryland	Harford Co.	Bel Air	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			2 West Broadway 21014		
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME						
NICHOLAS		POTA		MANOS				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES?		16b. SOCIAL SECURITY NO.		17. INFORMANT (Name) ADDRESS				
YES - Army		91342-31146		Mr. Augustus PANOS 12 North Atwood Road Bel Air, Maryland 21014				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY:								
IMMEDIATE CAUSE (a) CANCER OF COLON								
DUE TO, OR AS A CONSEQUENCE OF								
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last								
(b) OBSTRUCTION TO SMALL BOWEL								
DUE TO, OR AS A CONSEQUENCE OF								
(c)								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
					YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOT BY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
		HOUR A.M. MONTH DAY YEAR						
		P.M. 19						
21d. INJURY OCCURRED		21e. PLACE OF INJURY		21f. LOCATION				
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from JUNE 29, 1983, to AUGUST 5, 1983, that (I) (we) lost saw the deceased alive on AUGUST 5, 1983, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE					DEGREE		22c. DATE SIGNED	
LOUISE SULTAN					ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		5 Aug. 1983	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)					22e. ADDRESS			
LOUISE SULTAN					VAMC, PERRY POINT, MD			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION		
Burial		Aug. 8, 1983		Bel Air Memorial Gardens		Bel Air, Harford Co., Maryland 21014		
24. FUNERAL DIRECTOR				25. PREPARED BY		26. DATE		
Foster T. H. W. Broadway				AUG 8, 1983		J. J. G. G. G.		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MADE IN U.S.A.

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FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) ELMER M POTTER			2a. DATE OF DEATH MONTH DAY YEAR AUGUST 21 1983		2b. HOUR 7:45 a.m.
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR March 27 1922		6. AGE (IN YEARS LAST BIRTHDAY) 61 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Kentucky	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Cecil MD	
10. CITY OR TOWN OF DEATH Perry Point, Md.	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) VA Medical Center		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Post Engineer	12b. KIND OF BUSINESS OR INDUSTRY A.P.G.	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland			13b. COUNTY Cecil	13c. CITY OR TOWN Perryville	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST William Potter			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Vanie McCown		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) W.W. II 214-18-1678		17. INFORMANT ADDRESS Janet Bennett Port Deposit, Md. 21904	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).  
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a).

MULTIPLE MYELOMA

2030

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

## PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a

MEDICAL CERTIFICATION

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b. PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET	CITY OR TOWN COUNTY STATE
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from August 5, 1983, to August 21, 1983, that <input checked="" type="checkbox"/> (we) last saw the deceased alive on August 21, 1983, and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) (did not) view the body after death.			
22b. SIGNATURE <i>Eugene A. Jaeger</i>		DEGREE M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED August 21, 1983
22d. PHYSICIAN'S NAME (TYPE OR PRINT) EUGENE A. JAEGER, M.D.		22e. ADDRESS VA Medical Center, Perry Point, Md.	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE Aug. 23, 1983	23c. NAME OF CEMETERY OR CREMATORY St. Mark's Cemetery	23d. LOCATION CITY OR TOWN COUNTY STATE Perryville Cecil Maryland
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24. FUNERAL HOME <i>Patterson Funeral Home</i>	25a. DATE REC'D. BY REGISTRAR 8/21/83	25b. REGISTRAR'S SIGNATURE <i>John E. Coates</i>
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BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.


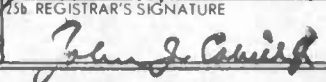
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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

21732

REG. NO.

1. FOR STATE REGISTRAR		2. DECEASED NAME (TYPE OR PRINT) <b>OLIN</b> FIRST MIDDLE LAST <b>Comegys Powell</b>										2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR <b>8 1 1983</b>				2b. HOUR <b>M</b>	
3. SEX <b>MALE</b>		4. RACE <b>CAUC</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>9 16 51</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>31</b> YRS.		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		2c. DATE PRONOUNCED DEAD <b>8 2 19 83</b>				2d. HOUR <b>2:40A</b> M	
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND</b>				7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH <b>Cecil County, MD.</b>					
10. CITY OR TOWN OF DEATH <b>Earleville</b>				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Westview Shores - Elk River</b>								12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>FARMER</b>				12b. KIND OF BUSINESS OR INDUSTRY <b>DAIRY</b>	
13a. STATE <b>MARYLAND</b>				13b. COUNTY <b>Kent</b>		13c. CITY OR TOWN <b>Kennedeville</b>				13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>Box 209 21645</b>					
14. FATHER'S NAME FIRST MIDDLE LAST <b>CHARLES POWELL</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>EDNA Comegys</b>													
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>NO</b>				16b. SOCIAL SECURITY NO. <b>216-56-1035</b>				17. INFORMANT ADDRESS <b>PARENTS - SAME</b>									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Drowning</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																	
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?										20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR <b>8:30P.M.</b> MONTH DAY YEAR <b>8 1 1983</b>				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) <b>Subject drowned while swimming</b>									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <b>river</b>				21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b>Elk River Earleville Cecil Md.</b>									
22a. I certify that I took charge of the remains described above, held on death resulted from: <input type="checkbox"/> Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion																	
ACTUAL SIGNATURE 				TITLE (SPECIFY) <b>M.D. Deputy Chief</b>				DATE SIGNED <b>8/2/83</b>									
EXAMINER'S NAME (TYPE OR PRINT) <b>Thomas D. Smith, M.D.</b>				ADDRESS <b>111 Penn St. Balto., MD.</b>													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>				23b. DATE <b>8-5-83</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Kennedeville Cem.</b>				23d. LOCATION CITY OR TOWN COUNTY STATE <b>Kennedeville Kent MD</b>							
24. FUNERAL DIRECTOR NAME <b>Edw. Fellows &amp; Son</b>				ADDRESS <b>MILLINGTON MD</b>				25a. DATE REC'D. BY REGISTRAR <b>AUG 12 1983</b>				25b. REGISTRAR'S SIGNATURE 					

WFO

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2005 - 2006

REPORT

WFO



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies, Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

#13abcde, Film G583 9/6/83 kam				STATE OF MARYLAND		21 / 33	
FOR #15				DEPARTMENT OF HEALTH AND MENTAL HYGIENE			
1. STATE REGISTRAR				CERTIFICATE OF DEATH			
REG. NO.							
1. DECEASED NAME (TYPE OR PRINT)				2a. DATE OF DEATH		2b. HOUR	
FIRST MIDDLE LAST ALVINE L. SCHMIDT				MONTH DAY YEAR August 5, 1983		9:30am	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)	
Female		White		MONTH DAY YEAR May 7, 1993		90 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH	
Wisconsin		U.S.A.				Perryville Cecil MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Perry Point, Md.		VA Medical Center		Army Nurse		Major	
13a. STATE				13b. CITY OR TOWN		13c. STREET ADDRESS	
Florida				Baltimore		11 Arapaho Dr. 32507	
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME			
FIRST MIDDLE LAST Gustav Schmidt				FIRST MIDDLE LAST Angeline Monte d Oro			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				16b. SOCIAL SECURITY NO.		17. INFORMANT	
Yes				WW 11		Mr. Florian Schmidt	
				545-58-6866		11 Arapaho Dr. Pensacola, Florida 32507	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)							
PART 1. DEATH WAS CAUSED BY:							
IMMEDIATE CAUSE (a) Cardio respiratory arrest							
DUE TO, OR AS A CONSEQUENCE OF (b) Cardio respiratory failure							
DUE TO, OR AS A CONSEQUENCE OF (c) Pneumonia, bilateral							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (this hospital) attended the deceased from February 23, 1976, to August 5, 1983, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE				DEGREE		22c. DATE SIGNED	
Julian Ocejio, M.D.				ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		8-5-83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS			
JULIAN OCEJO, M.D.				VA Medical Center, Perry Point, Md.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE	
Burial		8-8-83		Mt. Hope Cemetery		Osceola Wisconsin	
24. FUNERAL DIRECTOR				25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
8728 Liberty Road 21133				Aug 8 1983			
Loring Byers Funeral Service, Randallstown, Md.							



BP\_\_\_\_\_

DHMH - 17  
(VR A15 ME (5))  
15M 7/77

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		MIDDLE		LAST		2a. DATE KNOWN OF DEATH		ESTIMATED		MONTH		DAY		YEAR		2b. HOUR							
Myrtle		L.		Shaw		8		14		19		83											
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YR.		IF UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD		MONTH		DAY		YEAR		2d. HOUR			
Female		White		Oct. 26, 1906		76 YRS		MONTHS		DAYS		HOURS		MIN		8		14		1983		12:30 p.m.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)				7b. CITIZEN OF WHAT COUNTRY?				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH											
Maryland				U.S.A.								Cecil County											
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)								12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY							
Port Deposit				264 N. Main street								Housewife				-----							
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)																							
13a. STATE				13b. COUNTY				13c. CITY OR TOWN				13d. INSIDE CITY LIMITS?				13e. STREET ADDRESS							
Maryland				Cecil				Port Deposit				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				264 N. Main St. 21904							
14. FATHER'S NAME								15. MOTHER'S MAIDEN NAME															
FIRST MIDDLE LAST								FIRST MIDDLE LAST															
Oliver S. Lambert								Emma Boyd															
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)								16b. SOCIAL SECURITY NO.				17. INFORMANT ADDRESS											
No								212-32-3907				Betty L. Brunette Port Deposit, Md. 21904											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute myocardial infarction</u> 4100 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____																APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																							
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?												20. AUTOPSY?							
																YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)															
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE															
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .																							
ACTUAL SIGNATURE				TITLE (SPECIFY)								DATE SIGNED											
J. Vital				Deputy								8-14-83											
EXAMINER'S NAME (TYPE OR PRINT)				ADDRESS																			
Juan C Gonzalez-Vitale				Union Hospital, Elkton, Md								21921											
23a. BURIAL CREMATION, REMOVAL (SPECIFY)				23b. DATE				23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION CITY OR TOWN COUNTY STATE											
Burial				Aug. 17, 1983				West Nottingham Cem.				Colora Cecil Maryland											
24. FUNERAL DIRECTOR (NAME AND ADDRESS)				25a. DATE REC'D. BY REGISTRAR				25b. REGISTRAR'S SIGNATURE															
Lee A. Patterson & Son, Perryville, Maryland				AUG 19 1983				John J. Canine															



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>NORTON BENJAMIN SINGMAN</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>August 25, 1983</b>		2b. HOUR <b>9:40PM</b>
3. SEX <b>Male</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>SEPT. 3, 1915</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>67</b> YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 72 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>	7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Cecil</b> MD.	
10. CITY OR TOWN OF DEATH <b>Perry Point, Md</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>VA Medical Center 21902</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Haberdasher-Singmans Mens Store</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Owner</b>
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE <b>Maryland</b>		13b. COUNTY <b>Cecil</b>	13c. CITY OR TOWN <b>Elkton</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Jacob - Singman</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Anna - Rosenthal</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>		16b. SOCIAL SECURITY NO. <b>218-32-1948</b>		17. INFORMANT ADDRESS <b>Mrs. Sara W. Singman, Elkton, Md. 21921</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <b>4960</b> IMMEDIATE CAUSE (a) <b>RESPIRATORY ARREST</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>CHRONIC OBSTRUCTIVE PULMONARY DISEASE</b> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that <b>XX</b> (his hospital) attended the deceased from <b>7-23</b> , 19 <b>83</b> , to <b>8-25</b> , 19 <b>83</b> , that <b>X</b> (we) lost <b>him</b> (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>Prem Lal</b>		DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>8/25/83</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>PREM LAL, M.D.</b>		22e. ADDRESS <b>VA MEDICAL CENTER, PERRY POINT, MD.</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>8-29-1983</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Gilpin Manor Memorial Park, Elkton, Md/</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>21921</b>
24. FUNERAL DIRECTOR <b>HICKS FUNERAL HOME</b>		ELKTON, MARYLAND 21921		25a. DATE REC'D. BY REGISTRAR <b>AUG 31 1983</b>	
		25b. REGISTRAR'S SIGNATURE <b>John J. Connel</b>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 10 days of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP \_\_\_\_\_

HICKS, RICHARD H. - ELSTON, HAWAII 1901

1901

1901-1902

VA MEDICAL CENTER, PENNA POINT, MD.

PREL. LAL, H.D.

XX

XX

32

7-32

X

HICKS, RICHARD H. - ELSTON, HAWAII 1901

1901

1901-1902

VA MEDICAL CENTER, PENNA POINT, MD.

PREL. LAL, H.D.

XX

XX

32

7-32

X

RESPIRATORY ARREST

CHRONIC OBSTRUCTIVE PULMONARY DISEASE

218-32-1902

Jan 1902

1902-1903

1903

1903-1904

PENNA POINT, MD VA Medical Center

1903

1903-1904

HORTON, BENJAMIN SINGAPORE

August 25, 1903

9-1903

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR RECORDS. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED. WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

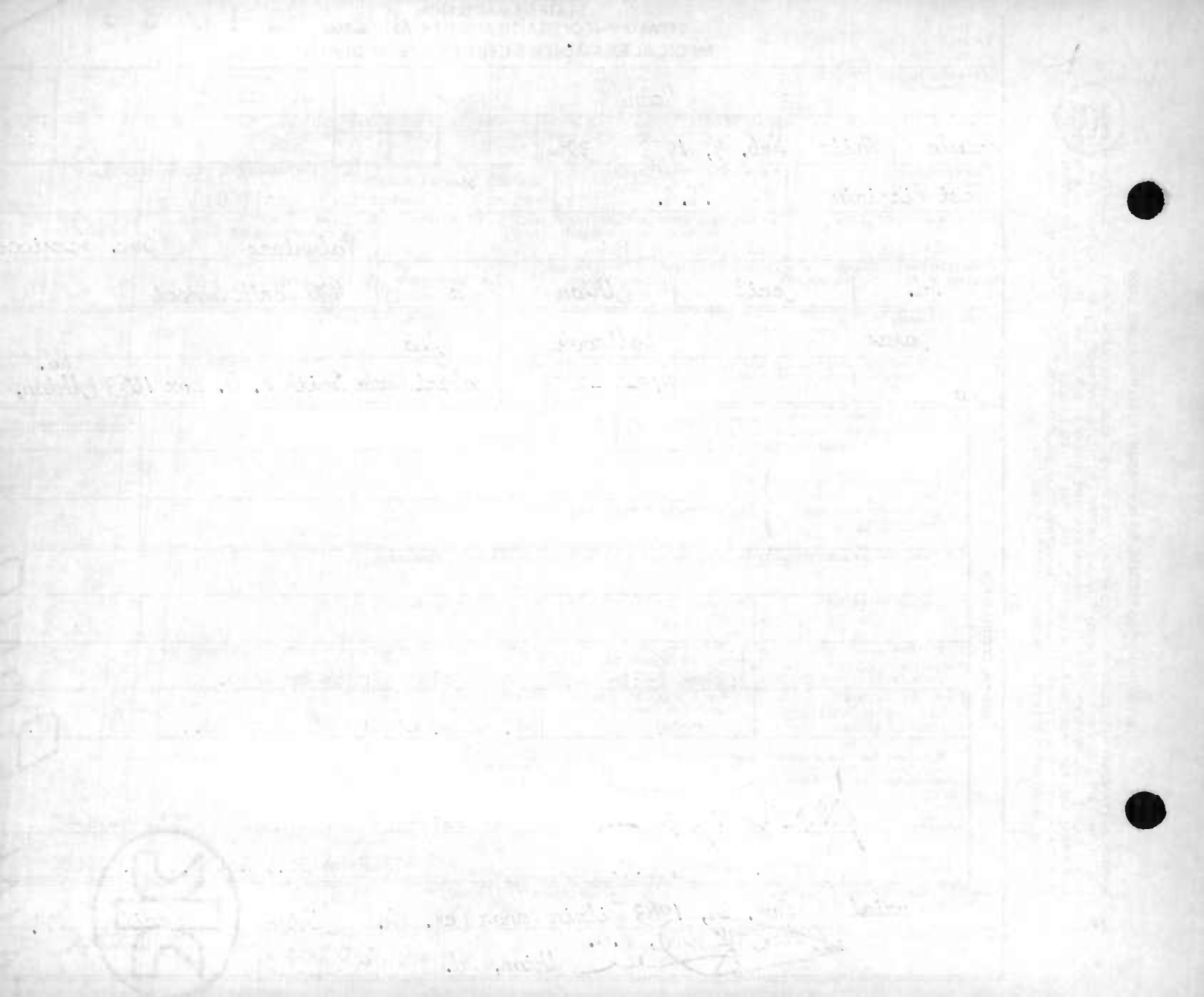
BP

DHMH - 17  
(VR A15 ME (5))  
20M 4/82

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1. FOR STATE REGISTRAR										2 1 7 3 6									
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST JOYCE Jean SMITH										2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR 8 21 1983									
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Feb. 9, 1953		6. AGE (IN YEARS LAST BIRTHDAY) 30 YRS.		IF UNDER 24 HRS. MONTHS DAYS HOURS MIN.		2c. DATE PRONOUNCED DEAD 8 21 1983		2d. HOUR 3:26 a.m.							
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) West Virginia				7b. CITIZEN OF WHAT COUNTRY? U.S.A.				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH Cecil County MD.							
10. CITY OR TOWN OF DEATH Elkton				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Union Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Volunteer				12b. KIND OF BUSINESS OR INDUSTRY Soc. Services							
13a. STATE Md.				13b. COUNTY Cecil		13c. CITY OR TOWN Elkton		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 430 North Street 21921									
14. FATHER'S NAME FIRST MIDDLE LAST James Holbrook						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Cleo													
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) no						16b. SOCIAL SECURITY NO. 213-68-3253		17. INFORMANT ADDRESS Robert Wade Smith P. O. Box 1063 Elkton, Md.											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple injuries 8147 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF (c) DUE TO, OR AS A CONSEQUENCE OF APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).																			
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 2:21xx 8-21- 1983				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Pedestrian struck by auto.											
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) road				21f. LOCATION STREET CITY OR TOWN COUNTY STATE Rt. 40 e. of Old Elk Neck Rd., Cecil Md.											
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .																			
ACTUAL SIGNATURE Ann M. Dixon				TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER				DATE SIGNED 8-21-83											
EXAMINER'S NAME (TYPE OR PRINT) Ann M. Dixon, M.D.				ADDRESS 111 Penn St., Balto., Md. 21201															
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE Aug. 24, 1983		23c. NAME OF CEMETERY OR CREMATORY Gilpin Manor Mem. Pk.				23d. LOCATION CITY OR TOWN COUNTY STATE Elkton Cecil Md.									
24. FUNERAL DIRECTOR NAME SEE PLAIN PAPER				25a. DATE REC'D. BY REGISTRAR AUG 26 1983				25b. REGISTRAR'S SIGNATURE John D. Smith											



TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours of the death. The law also requires that the death certificate be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) <b>JOHN NELSON SPARKS</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>AUGUST 1, 1983</b>		2b. HOUR <b>7A</b> M	
3. SEX <b>MALE</b>	4. RACE <b>CAUCASIAN</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>DEC 30 1891</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>91</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>DELAWARE</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>CECIL</b> MD.			
10. CITY OR TOWN OF DEATH <b>WARWICK</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>GRAHAM NURSING HOME</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>RET FARMER</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>DIRT FARM</b>		
13a. STATE <b>DELAWARE</b>	13b. COUNTY <b>NEW CASTLE</b>	13c. CITY OR TOWN <b>ST GEORGES</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS <b>MAIN ST. 99999</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>EDWARD (NM) SPARKS</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>ANNA (NM) NELSON</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>221-22-3986</b>		17. INFORMANT <b>JOHN N. SPARKS JR</b> ADDRESS <b>5 REDDING ST MIDDLETOWN DEL</b>			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: <b>7070 IMMEDIATE CAUSE (a) <u>sepsis</u></b> DUE TO, OR AS A CONSEQUENCE OF (b) <u>decubitus ulcers/urinary tract infection</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>Kenneth S. Lewis MD</b>				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>KENNETH S. LEWIS</b>				22e. ADDRESS <b>12 PENNINGTON ST. MIDDLETOWN DEL.</b>			
23a. BURIAL, CREMATION, REMOVAL (TYPE OR PRINT) <b>BURIAL</b>		23b. DATE <b>AUG 3, 1983</b>		23c. NAME OF CEMETERY OR CREMATORY <b>ST GEORGES</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>ST. GEORGES NEW CASTLE DEL</b>	
24. FUNERAL DIRECTOR NAME <b>Geo Funeral Home</b>		ADDRESS <b>259 E. MAIN ST ELKTON, MD.</b>		DATE RECEIVED BY REGISTRAR <b>AUG 8 1983</b> <b>John S. Lewis</b>			

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Handwritten notes on lined paper, including the word "MAY" and other illegible text.

Handwritten notes on lined paper, including the word "MAY" and other illegible text.

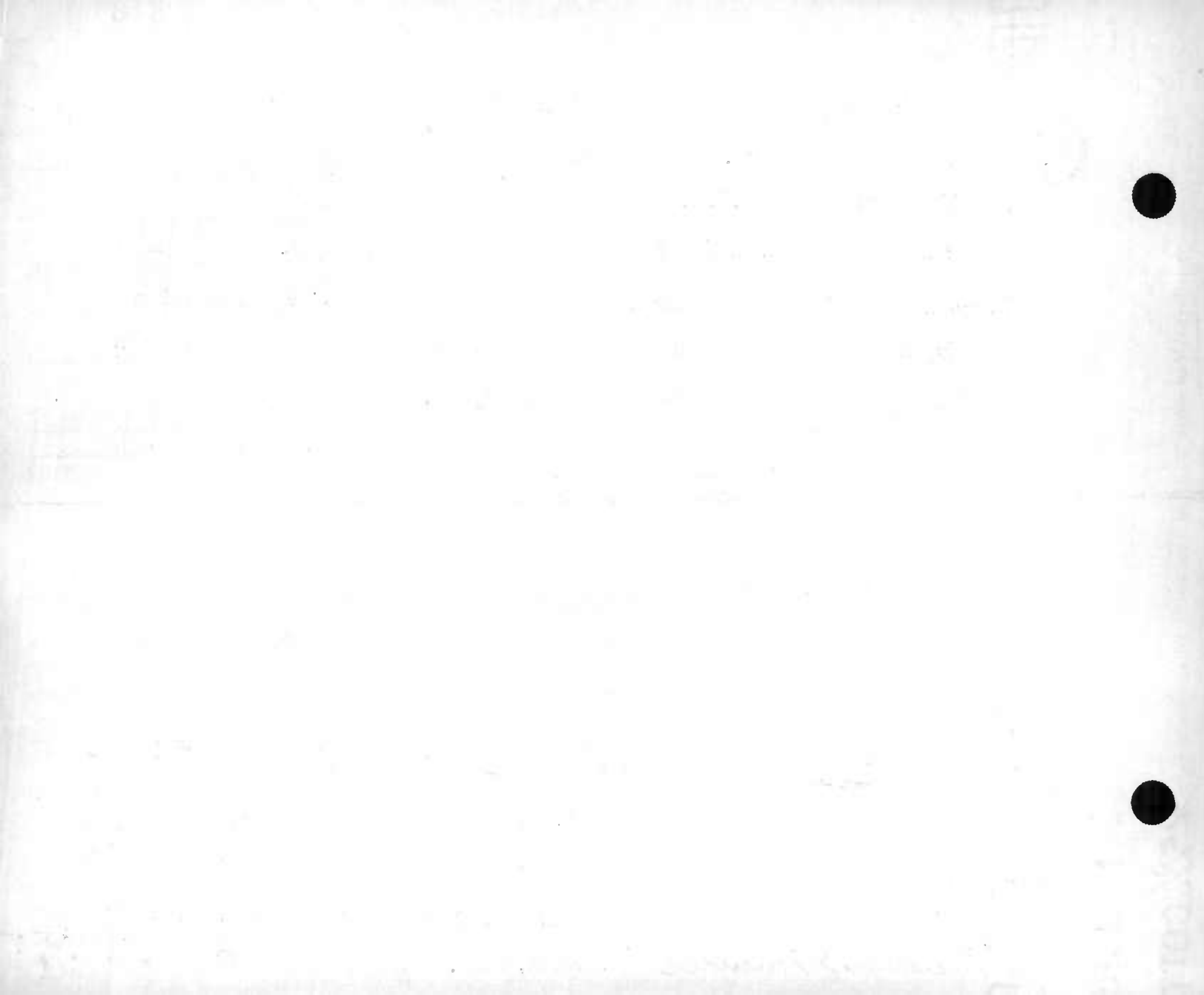
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of one.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH																	
1. FOR STATE REGISTRAR		REG. NO.															
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH		MONTH		DAY		YEAR		2b. HOUR	
ROSE		V		SPIESS				8		5		83		2:15		P.M.	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR		8. IF UNDER 24 HRS		9. BALTIMORE CITY OR COUNTY OF DEATH		10. MD.			
Female		Cauc.		5-22-1900		83		YRS		MONTHS		DAYS		HOURS		MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>													
New York City NY		U.S.A.															
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY											
Elkton		Union Hospital		Housewife													
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS									
Maryland		Cecil		Elkton		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		7 Woods Road, Glen Farms									
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME															
Eugene		Marie		Anderson													
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS											
No		051-10-8171		George W. Spiess		Same											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinomatosis, unknown primary site,</u> <u>1990</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>With extensive pulmonary &amp; hepatic disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Hypertension</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>Unknown</u>															
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?											
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>											
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)													
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE													
22a. I certify that (this hospital) attended the deceased from <u>7/20</u> 19 <u>83</u> , to <u>8/5</u> 19 <u>83</u> , that (we) last saw the deceased alive on <u>8/5</u> 19 <u>83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (we do not) view the body after death.																	
22b. SIGNATURE <u>Edgar E. Folk</u>		DEGREE <u>M.D.</u>		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <u>8/6/83</u>											
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Edgar E. Folk M.D.</u>		22e. ADDRESS <u>Union Hospital, Elkton, Md.</u>															
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		23b. DATE <u>8-9-1983</u>		23c. NAME OF CEMETERY OR CREMATORY <u>All Saints Cemetery</u>		23d. LOCATION CITY OR TOWN COUNTY STATE <u>Kirkwood Hwy. N.C. Deldware</u>											
24. FUNERAL DIRECTOR NAME <u>Freeman J. Narvick</u>		ADDRESS <u>Newark, Dela.</u>		25a. DATE REC'D. BY REGISTRAR <u>AUG 9 1983</u>		25b. REGISTRAR'S SIGNATURE <u>John J. Connel</u>											

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed within 10 days of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.			
1. FOR Item 19b film 583 STATE REGISTRAR 9-23-83 cn				21739			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>ARCHIE SPINNEY</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>August 14, 1983</b>		2b. HOUR <b>10:30pm</b>	
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>1 28 01</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>82</b> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maine</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Cecil County</b> MD.	
10. CITY OR TOWN OF DEATH <b>Perry Point, Md.</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>VA Medical Center</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Superintendent</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Construction</b>	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Maryland</b>				13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Baltimore</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Herbert H. Spinney</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Bessie H. Mitchell</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>yes</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>WW 11 215-05-3653</b>		17. INFORMANT ADDRESS <b>Irene M1 Spinney Balto., Md. 21214</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: <b>5750</b> IMMEDIATE CAUSE (a) <b>Acute cholecystitis</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Autopsy</b> <b>Stomach---Partial only-----</b>		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>February 9, 1981</b> to <b>August 14, 1983</b> XXXXXXXX and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>Louise Sultan M.D.</b>				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>8-15-83</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>LOUISE SULTAN, M.D.</b>				22e. ADDRESS <b>VAMC, Perry Point, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>8-18-83</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Dulaney Mem. Gard.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Balto., Md.</b>	
24. FUNERAL DIRECTOR NAME <b>Lassahn Funeral Home, Baltimore, Md. 21236</b>				25a. DATE REC'D. BY REGISTRAR <b>AUG 19 1983</b>		25b. REGISTRAR'S SIGNATURE <b>John J. Carver</b>	

Abstract

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 4 and 5 should be retained by the funeral director within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 21740			
1. DECEASED NAME [TYPE OR PRINT] OTIS WHITE				2a. DATE OF DEATH MONTH DAY YEAR August 5, 1983			
3. SEX MALE				2b. HOUR 8:10p M			
4. RACE BLACK		5. DATE OF BIRTH MONTH DAY YEAR 11 29 08		6. AGE (IN YEARS LAST BIRTHDAY) 74 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
9. CITY OR TOWN OF DEATH PERRY POINT		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) VA Medical Center Perry Point, MD		9. BALTIMORE CITY OR COUNTY OF DEATH Cecil County MD.			
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		13a. STREET ADDRESS 861 Balto. & Annapolis Blvd.			
13a. STATE MARYLAND		13b. COUNTY A.A.		13c. CITY OR TOWN SEVERNA PARK		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST ARTHUR WHITE		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST CARRIE WATTS		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES W.W.II			
16b. SOCIAL SECURITY NO. 219-16-0816		17. INFORMANT MABEL WHITE		ADDRESS 861 Balto. & Annapolis Blvd. Severna Pk, Md. 21146			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 1850 IMMEDIATE CAUSE (a) MALIGNANT METASTASES DUE TO, OR AS A CONSEQUENCE OF (b) CARCINOMA OF PROSTATE Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (c)							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I:							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from Apr 22, 19 82, to Aug 5, 19 83, that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on Aug 5, 19 83, and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) <input type="checkbox"/> (did not) view the body after death.							
22b. SIGNATURE Glendon Rayson		DEGREE M.D.		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 8-6-83	
22d. PHYSICIAN'S NAME [TYPE OR PRINT] GLENDON, RAYSON, M.D.		22e. ADDRESS VMC PERRY POINT, MD.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 8-10-1983		23c. NAME OF CEMETERY OR CREMATORY CARPENTER HILL CEME.		23d. LOCATION CITY OR TOWN COUNTY STATE Round Bay A.A. Maryland	
24. FUNERAL DIRECTOR NAME WILLIAM REESE & SONS MORTUARY, P.A.		25a. DATE REC'D. BY REGISTRAR AUG 11 1983		REGISTRAR'S SIGNATURE John J. Carroll			
Reese Funeral Home, Annapolis, MD 21401							

UNITED STATES  
DEPARTMENT OF THE ARMY  
OFFICE OF THE CHIEF OF MEDICAL SERVICE

DATE: 10-10-50  
TO: THE CHIEF OF MEDICAL SERVICE  
FROM: THE CHIEF OF MEDICAL SERVICE

SUBJECT: [Illegible]  
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of this certificate is to be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified by page.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) <b>George A. Woodall</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>8/18/83</b> 2b. HOUR <b>6:20 P</b>	
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>NOVEMBER 30, 1904</b>	
6. AGE (IN YEARS LAST BIRTHDAY) <b>78</b> YRS.		7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		8. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
9. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		10. CITIZEN OF WHAT COUNTRY? <b>USA</b>		11. BALTIMORE CITY OR COUNTY OF DEATH <b>Cecil</b>	
12. CITY OR TOWN OF DEATH <b>Elkton</b>		13. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Union Hospital</b>		14. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Carpenter</b>	
15. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 15a. STATE <b>Maryland</b> 15b. COUNTY <b>Cecil</b> 15c. CITY OR TOWN <b>Elkton</b>		16. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		17. STREET ADDRESS <b>8 Halls Lane 21921</b>	
18. FATHER'S NAME FIRST <b>Maxwell</b> MIDDLE <b>-</b> LAST <b>Woodall</b>		19. MOTHER'S MAIDEN NAME FIRST <b>Ella</b> MIDDLE <b>R.</b> LAST <b>Register</b>		20. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>	
21. SOCIAL SECURITY NO. <b>222-09-7829A</b>		22. INFORMANT <b>Mrs. Mary R. Woodall, Elkton, Md. 21921</b>		23. ADDRESS	
24. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac Arrest</b> <b>4960</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Myocardial Infarction</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>COPD</b>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)					
25a. DATE OF OPERATION		25b. CONDITION FOR WHICH OPERATION WAS PERFORMED		26a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
27a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		27b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		27c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
28a. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		28b. PLACE OF INJURY (AT HOME STREET FACTORY, OFFICE, FARM, ETC.)		28c. LOCATION CITY OR TOWN COUNTY STATE	
29. I certify that (I) (this hospital) attended the deceased from <b>8-18</b> 19 <b>83</b> , to <b>8-18</b> 19 <b>83</b> , that (I) (we) last saw the deceased alive on <b>8-18</b> 19 <b>83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
30. SIGNATURE <b>Sheelmohan S. Sachdev</b>				31. DATE SIGNED <b>8-18-83</b>	
32. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Sheelmohan S. Sachdev MD.</b>				33. ADDRESS <b>Elkton, Md</b>	
34a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		34b. DATE <b>8-22-83</b>		34c. NAME OF CEMETERY OR CREMATORY <b>Elkton Cemetery</b>	
34d. FUNERAL DIRECTOR <b>Ralph E. Hicks</b>		34e. ADDRESS <b>HICKS HOME for FUNERALS, ELKTON, MD. 21921</b>		35. DATE REC'D. BY REGISTRAR <b>AUG 25 1983</b>	
36. REGISTRAR'S SIGNATURE <b>John J. Carver</b>				37. REGISTRAR'S SIGNATURE	

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4-5-1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed in the 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) <b>LEROY F. WOODMAN -</b>				2a. DATE OF DEATH MONTH <b>8</b> DAY <b>12</b> YEAR <b>83</b> HOUR <b>12:50 AM</b>			
3. SEX <b>MALE</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH <b>FEBRUARY</b> DAY <b>1</b> YEAR <b>1928</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>55</b> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maine</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Cecil</b> MD.	
10. CITY OR TOWN OF DEATH <b>Elkton</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Union Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Tug Master - East Coast Tender</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Service</b>	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Delaware</b> 13b. COUNTY <b>New Castle</b> 13c. CITY OR TOWN <b>Newark</b>				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
14. FATHER'S NAME FIRST <b>Ralph</b> MIDDLE <b>K.</b> LAST <b>Woodman</b>				15. MOTHER'S MAIDEN NAME FIRST <b>Teresa</b> MIDDLE <b>-</b> LAST <b>Doyle</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b> (IF YES, GIVE WAR OR DATES) <b>WW 2</b>				16b. SOCIAL SECURITY NO. <b>004-26-6004</b>		17. INFORMANT ADDRESS <b>Mrs. P. Dale Woodman, Newark, Del. 19702</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: <b>1541</b> IMMEDIATE CAUSE (a) <b>Carcinoma Rectum</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>with Mets Liver &amp; Lungs -</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Renal failure -</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>8/11/83</b> to <b>8/12/83</b> , that (I) (we) lost saw the deceased alive on <b>8/11/83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>Jayantical K. Patel MD</b>				DEGREE <b>MD</b> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>8/12/83</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>JAYANTICAL K PATEL MD</b>				22e. ADDRESS <b>123 Singlerly Ave Elkton MD 21921</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>8-16-83</b>		23c. NAME OF CEMETERY OR CREMATORY <b>North East Methodist Cemetery, North East, Md. 21901</b>		23d. LOCATION CITY OR TOWN COUNTY STATE	
24. FUNERAL DIRECTOR NAME <b>James W. Hicks</b> ADDRESS <b>HICKS HOME for FUNERALS, ELKTON, MD. 21921</b>				25a. DATE REC'D. BY REGISTRAR <b>AUG 19 1983</b>		25b. REGISTRAR'S SIGNATURE <b>John J. Canine</b>	



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		2a. DATE OF DEATH		2b. HOUR	
FIRST MIDDLE LAST Rosalie S. Yeater		MONTH DAY YEAR 8/24/83		1600 A M	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)	7. UNDER 1 YEAR	
Female	White	MONTH DAY YEAR SEPT. 4, 1912	70 YRS.	MONTHS DAYS HOURS MIN.	
8. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	9b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH		
Maryland	USA		Cecil Co MD.		
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY		
Elkton	Union Hospital	Clerk - Appleton Market			
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS	
Maryland	Cecil	Elkton	YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	1215 Appleton Road 21921	
14. FATHER'S NAME	15. MOTHER'S MAIDEN NAME	16. ADDRESS			
FIRST MIDDLE LAST Frank - Szuleski	FIRST MIDDLE LAST Josephine - Sdun				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	16b. SOCIAL SECURITY NO.	17. INFORMANT			
No	218-01-0417A	Mr. William G. Kapp, Elkton, Md. 21921			
18. CAUSE OF DEATH (Enter only one cause per line (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory Failure</u> 3429 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Pneumonia</u> (c) <u>Hemiplegia &amp; Complete Aphasia.</u>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?	
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>7/14</u> , 19 <u>83</u> , to <u>8/24</u> , 19 <u>83</u> , that (I) (we) last saw the deceased alive on <u>8/24/83</u> , 19 <u>83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death.					
22b. SIGNATURE		DEGREE		22c. DATE SIGNED	
Sheelmochar S. Sachdev		M.D.		8/29/83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS			
Sheelmochar S. Sachdev		Elkton, Md.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE	23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION
Burial		8-26-83	Gilpin Manor Memorial Park, Elkton, Md.		21921
24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
HICKS HOME FOR FUNERALS, ELKTON, MD. 21921		AUG 31 1983		Jan E. Curren	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

CHIEFLY

20% CO. ON FILE

